HIGHMARK Delaware | Freedom Blue PPO

FREEDOMBLUE MEDICARE ADVANTAGE
HIGHMARK BCBSD INC.
GROUP ACCOUNT AGREEMENT

This Group Account Agreement (the "Agreement") has been entered into between Highmark BCBSD Inc.("the Health Plan"), and the State of Delaware(the "Group").

The Health Plan, in consideration of the monthly payments to be paid to Health Plan by the Group or by the Member (as hereinafter defined), agrees to provide those Medicare eligible persons who enroll ("Members") under a Medicare Advantage program ("MA Plan") for the Covered Services (as defined in the Evidence of Coverage (including the Medical Benefits Chart), in accordance with the terms, conditions, limitations and exclusions of this Agreement and the Evidence of Coverage. In the event of a conflict between this Agreement and any other documents relevant to coverage for the Covered Services, the terms and conditions of the Evidence of Coverage including any addenda thereto shall apply and shall be deemed to supersede any conflicting terms and conditions.

ARTICLE I - GROUP ELIGIBILITY

On the Commencement Date (hereinafter defined) of this Agreement, the parties agree that Group is not subject to any minimum number of enrolled Members in order to be eligible for the MA Plan so long as Health Plan is the exclusive medical plan offering for all Group's Medicare-eligible participants.

ARTICLE II - TERM AND TERMINATION

This Agreement shall continue in effect from year to year, beginning on January 1, 2023 (the "Commencement Date"), for a minimum period of three years ending December 31, 2025 as set forth more fully herein. The Group has a right to terminate at the end of the three-year contract period by providing one hundred twenty (120) days' prior written notice to Health Plan. Health Plan has the right to terminate this Agreement by giving sixty (60) days prior written notice to the Group in the event the Group fails to pay any premium due. The Group and Health Plan acknowledge and agree that the coverage provided hereunder for each of the Members is in consideration of payments made by the Group on behalf of each such Member, as provided below. Health Plan has the right to disenroll any Member if the Group does not pay the premium on behalf of such Member. If the Group terminates this Agreement for any reason, Health Plan shall have no liability to any Member, except as specifically provided hereunder or under applicable laws and regulations. Any disenrollment of a Member shall be done in accordance with the Evidence of Coverage.

ARTICLE III - SERVICE AREA

The service area for this Agreement shall be the geographical areas designated by Health Plan (the "Service Area"), as approved by the Centers for Medicare and Medicaid Services ("CMS"). For purposes of this Agreement, the Service Area shall include all 50 states, the District of Columbia, and all United States territories.

ARTICLE IV - RATES

Group shall have no plan premium for the MA Plan during the first year and for the following two years (calendar years 2024 and 2025, respectively) during this Agreement. As applicable, rates per Member per month ("PMPM") under this Agreement shall be payable to Health Plan by the Group on behalf of each such Member by the 30th day of the coverage month under this Agreement as follows

January 1, 2023 through December 31, 2023	$0
January 1, 2024 through December 31, 2024	$0
January 1, 2025 through December 31, 2025	$0

If Group elects to renew this Agreement for calendar years 2026 and/or 2027, then the MA Plan will be subject to guaranteed rate caps as outlined below and as subject to Article V. Rates per Member per month under this Agreement shall be payable to Health Plan by the Group on behalf of each such Member by the 30th day of the coverage month.

YEAR	GUARANTEED RATE CAP
January 1, 2026 through December 31, 2026	$5
January 1, 2027 through December 31, 2027	$10

Group acknowledges that rates and/or rate-related terms and conditions of this Agreement are subject to the conditions set forth in Article V below. If any of the conditions set forth in Article V become applicable, Health Plan agrees to provide written notice to Group within thirty (30) days of the Group becoming aware of the Article V condition in the form of a renewal addendum detailing any such anticipated changes to rates and/or rate-related terms and conditions. Group acknowledges that the new rates and/or rate-related terms and conditions will be effective on the next January 1 following the Group (i) signing and returning such renewal addendum to Health Plan, which represents an express acceptance of the new rates and/or rate-related terms and conditions contained therein, and Group agrees to be legally bound thereunder unless Group specifically terminates this Agreement pursuant to the required procedure set forth above; or (ii) continuing to treat the Agreement as being in effect and failing to notify Health Plan in writing of its termination of the Agreement within the required notice period set forth above in Article II., Group and Health Plan acknowledge and agree that the executed renewal addendum shall be incorporated into this Agreement and made a part hereof as a rider, and the terms and conditions contained therein shall have the same force and effect of the other provisions of this Agreement.

Group agrees that if it pays or subsidizes all or any portion of the rate due for a Member, it will do so in accordance with the following:

1. If Group pays or subsidizes different amounts of rates for different classes of Members, the class differentiation must be reasonable and based on objective business criteria, such as years of service, business location, job category, and nature of compensation (hourly vs. salaried) and not on eligibility for the Low-Income Subsidy (as defined below);
2. The rate paid by a Member cannot vary within a class of Members;

ARTICLE V – GUARANTEED RATE CAP AND PREMIUM CONDITIONS

The maximum premium shown for all years is based upon Health Plan retaining at least 30,000 active contracts (includes all active employees and non-Medicare retiree contracts). If the active contract count is below 30,000 on July 1 prior to the calendar year of the MA Plan coverage, then all the premiums and guaranteed rate caps outlined in this Article IV will increase by $19 PMPM.

The guaranteed rate caps in calendar years 2026 and 2027 are subject to achievement of a minimum Medical Loss Ratio ("MLR") as outlined below:

Calendar Year 2026 (MLR measured from July 1, 2023 through June 30, 2024)

MLR <90%	$0 premium
If 90% <=MLR <=95%	$5 maximum premium (expected premium reflected in the above table)
MLR >95%	$20 maximum premium

Calendar Year 2027 (MLR measured from July 1, 2024 through June 30, 2025)

MLR <90%	$0 premium
If 90% <=MLR <=95%	$10 maximum premium (expected premium reflected in the above table)
MLR >95%	$30 maximum premium

For purposes of this Agreement, MLR is defined as (Incurred Claim Expenses + Provider Capitations + Provider/Vendor Managed Care Incentives and Payments) / (CMS Revenue + Client Premium)

In the event of a benefit change during the MLR measurement period, Highmark will make an adjustment to the MLR calculation to reflect the expected net actuarial value of the impact of the benefit change. The net adjustment will account for both the impact to incurred claims as well as any offsetting premium/revenue that may be associated with the change.

Further, the following Additional Premium Considerations conditions apply to the premium guarantees for all years:

Network contracting – There are no legislative or regulatory changes that would materially impact Health Plan's ability to contract for an efficient provider network.

CMS funding – There are no legislative or regulatory changes that reduce CMS revenue funding for Medicare Advantage, including, but not limited to, the following components: 1) benchmarks; 2) rebates; 3) coding and/or risk adjustment; and 4) Stars and/or quality bonuses.

Regulatory changes – There are no legislative, regulatory, or enforcement actions that cause a material change to any of the following: 1) benefits offered; 2) claim payment requirements or procedures; 3) taxes, fees, or assessments; 4) sequestration; 5) expected claim payment levels (for example, State or Federal Mandates that impact provider reimbursements, PCP payment levels, etc.); and 6) any other changes affecting the manner or cost of providing coverage that is required because of legislative or regulatory action.

Out-to-bid provision – Rate guarantees for calendar years 2026 and 2027 will be terminated if Group puts its Medicare Advantage coverage out to bid for the 2026 or 2027 calendar years.

Use of pharmacy data for medical management – The medical rates assume that Health Plan receives pharmacy data feeds every two weeks in a mutually agreed upon format from the Group's designated third party. The medical rates are subject to revision if either of these conditions do not occur. Health Plan agrees to work directly with the Group's prescription drug third party administrator to develop and implement appropriate pharmacy data feeds.

End stage renal disease – Group agrees not to enroll Members and their dependents who are Medicare beneficiaries diagnosed with End Stage Renal Disease ("ESRD Beneficiaries") in the MA Plan during the 30-month coordination period. Note, however, this provision does not apply to a Member who develops end stage renal disease while enrolled in the MA Plan. Further, this provision does not apply to a Member who has met the 30-month coordination period, leaves the MA Plan, and then subsequently reenrolls in the MA Plan.

Benefit Plan Changes – There are no material changes to the products, programs, current or proposed benefits under the Medicare Advantage medical plan.

Employer contribution requirements – This Agreement is based on a minimum employer contribution level of 50% of the group premium for the medical plan. If the average employer contribution falls below 50%, the medical plan rates are subject to revision.

ARTICLE VI – GAIN SHARE

This Agreement includes a Medicare Advantage Retrospective Gain Share ("Gain Share") with Group with separate settlements for each calendar year 2023 through 2025, as well as calendar years 2026 and 2027, if applicable.

Any reconciliation amount determined according to this Gain Share provision will be paid by Health Plan in a lump sum settlement. Interest will not accrue on the payments. Upon termination or non-renewal of the Agreement, Health Plan will pay Group 50% of any amount due related to the last year of coverage.

The parties understand that CMS usually performs a final payment reconciliation of CMS revenue in June of the calendar year following the year of coverage and that this is a critical part of the revenue calculation. Therefore, the reconciliation and any gain share payment will occur within 60 days after the CMS final payment is released for a given calendar year. The timing is subject to change if CMS changes the schedule of its final payment.

The Gain Share will be reconciled in aggregate across all retiree sub-groups and will be calculated as follows:

Actual Medicare Advantage Incurred Medical Loss Ratio (MLR)	**Each calendar year of coverage will be measured independently**
If the MLR is greater than or equal to 88.0%, then	There is no gain share payment
If the MLR is between 86% and 88% then:	Health Plan will pay a lump sum payment equal to 50% of the difference between the actual MLR and 86%

If the MLR is less than 86% then:	Health Plan will pay a lump sum payment equal to: • 50% of the value between 86% and 88% plus • 80% of the difference between the Actual MLR and 86%

The **Medical Loss Ratio (MLR)** will be calculated as follows:

[Incurred Claim Expenses + Provider Capitations + Provider/Vendor Managed Care Incentives and Payments]

Divided by

[CMS Revenue + Client Premium]

If CMS retroactively adjusts revenues paid to Health Plan with respect to the Group's Medicare Advantage coverage, impacting the total revenue used in the Gain Share calculation, Health Plan reserves the right to provide a revised reconciliation based on corrected CMS revenue data and the Group shall reimburse Health Plan for any overpayments. Such amounts shall be paid within one hundred twenty (120) days of receipt of the reconciliation. The maximum liability of Group is limited to the value of any gain share payments received. This provision survives the termination of this Agreement.

For purposes of this Article VI, the following definitions and assumptions shall apply:

Incurred Claim Expenses are on an incurred basis, including fee-for-service (FFS) and non-FFS claims, as well as a provision for Incurred but Not Reported (IBNR) claims.

Provider Capitations are any payments to providers paid on a capitated basis

Provider/Vendor Managed Care Incentives and Payments are any payments/incentives to providers or vendors related to value-based reimbursement arrangements, STARS, and/or Risk Adjustment

CMS Revenue includes amounts paid to Health Plan by CMS on behalf of State of DE Group Members.

Client Premium includes amounts paid to Health Plan by Group for the Medicare Advantage coverage.

ARTICLE VII – PERFORMANCE GUARANTEES

This Agreement is subject to performance guarantees by Health Plan as outlined in Exhibit 1, which is attached hereto and by reference incorporated into this Agreement.

ARTICLE VIII – REPORTING

The Health Plan agrees to provide reporting as defined and outlined by Health Plan in Exhibit 2, which is attached hereto and by reference incorporated into this Agreement.

As part of the reporting outlined by the health plan Exhibit 2, the Health Plan agrees to provide the specific reports as indicated below related to prior authorizations and appeals:

1. Total number of prior authorizations submitted, the percentage approved, the percentage of denials, in total and for defined service categories on a monthly basis.
2. Initial prior authorization decisions timing for standard and urgent/expedited requests on a monthly basis.
3. Number of prior authorization denial appeals received at 1st level – 5th level appeal on a quarterly basis.
4. Percentage of appeals that are upheld or overturned at 1st level appeal – 5th level appeal on a quarterly basis.

Attached as Exhibit 3 is a list of the current items, procedures and/or services for which prior authorization is required. The Health Plan's prior authorization list is subject to change, and the Health Plan has the authority to add or remove items, procedures and/or services from the prior authorization list at its sole discretion.

ARTICLE IX - IMPLEMENTATION

The parties agree to the following related to implementation of MA Plan:

- The Health Plan will suspend outpatient prior authorization requirements for Members for a four-month period beginning January 1, 2023 and ending May 1, 2023;
- The Health Plan shall provide $600,000 to the Group to offset the costs of the Group's communications to its participants and other costs associated with the Group's transition to the MA Plan ("Implementation Offset").
- The Implementation Offset shall be paid to the Group as an ASO administrative fee invoice credit towards the Group's administrative fees for December 2022.
- If Group cancels before the Commencement Date of this Agreement, Group shall refund the Health Plan the Implementation Offset within ten (10) business days following the cancelation.

ARTICLE X - CUSTOMER SERVICE AND CONCIERGE SUPPORT

The Health Plan agrees to provide direct concierge support to the Group and its members during the implementation period and throughout the duration of this contract. The Health Plan agrees to provide direct concierge support to members regarding provider network status in lieu of steering group members to the Health Plan self-navigate online option. The Health Plan further agrees to the following during the duration of this contract:

- Designated customer service team with a dedicated toll-free line for the Group, to be owned by the Health Plan;
- Customer service and culture trainings conducted by the Group and/or the Health plan as needed;
- The Health Plan will be responsible for the employment of an Executive Client Manager who will be dedicated to the Group account for the full duration of Agreement;
- The Group will have final approval of selected candidate for Executive Client Manager position; and
- Health Plan will hire, train, and retain a designated Medicare Advantage concierge service team for the Group for the duration of the Agreement.

ARTICLE XI - BENEFIT CHANGES

The benefit plan design of Health Plan for the Group is subject to change annually at the beginning of each calendar year in accordance with CMS guidelines and subject to CMS approval. Health Plan reserves the right to revise the benefit selection it provides to conform to changes made by CMS during the course of the calendar year. Additionally, the Group may change the benefit selection during the year by providing at least one hundred and eighty (180) days advance written notice to the Health Plan. In the event such changes affect the costs of Health Plan, Health Plan reserves the right to modify premium rates accordingly. Changes will be effective on the first day of the month immediately after the one hundred and eighty (180) day notice period has lapsed or at an agreed upon date. The Group agrees to provide all Members with at least twenty-one (21) days advance written notice of any changes.

ARTICLE XII - OPEN ENROLLMENT

The Group agrees to provide an annual coordinated election held during a designated period of time during the last four months of each calendar year (the "Open Enrollment Period"). The enrollment becomes effective the first day of the following year (January 1). The annual Open Enrollment Period shall, at minimum, consist of notification of retiree health benefit options, changes in premiums or benefits and the ability to enroll or disenroll, and other notifications required by CMS; and all such information shall be provided by Health Plan.

The Group will provide Health Plan (as directed by Health Plan) with requested information as to which employees or retirees are eligible to be Members (as set forth in the Evidence of Coverage and subject to applicable law).

Group agrees that employees or retirees can enroll using a Group enrollment process as allowed by CMS.

Health Plan will accept enrollment directly from Group without receiving an election form from each employee or retiree. Group agrees that in order to use this process:

i. Group must submit to Health Plan enrollment information that accurately reflects Group's record of the coverage election made by each individual.

ii. Group agrees that the beneficiary notice requirements prescribed by CMS are not changed by using this Group enrollment process. Group further agrees that each employee's or retiree's enrollment request must clearly denote his/her agreement to abide by Health Plan rules, certify his/her receipt of required disclosure information and include authorization by the beneficiary for the disclosure and exchange of necessary information between the U.S. Department of Health and Human Services (and its designees) and Health Plan.

iii. The enrollment request transaction must include all the data necessary for Health Plan to determine each individual's eligibility to make an enrollment request. Such data shall include at least the following: MA Plan name; MA plan/product choice; beneficiary name (first and last); beneficiary Medicare number (HICN); beneficiary date of birth; gender; permanent residence address or P.O. Box; authorized representative contact information (if applicable); and Part A and Part B effective dates.

iv. The effective date will generally be the first day of the month after the month Health Plan receives the completed enrollment request or the date specified by the Group.

v. Group and Health Plan's electronic enrollment transactions must, at a minimum, comply with CMS security policies. Examples of this method are 'FTP' file, password protected spread sheets or encrypted files.

vi. Group's record of the request to enroll must exist in a format that can be easily, accurately and quickly reproduced for later reference by each individual member, Health Plan and/or CMS, as necessary. Group shall send this record to Health Plan within three (3) business days of receipt of Health Plan's written request. The record shall be maintained by Health Plan for ten (10) years or through the date of the completion of any CMS audit, whichever is later.

ARTICLE XIII - DISENROLLMENT

In certain circumstances, a Member may be disenrolled on either a voluntary or involuntary basis. Group and Health Plan will work cooperatively to ensure that Member disenrollments are handled in accordance with the CMS Enrollment and Disenrollment Guidance. At a minimum, disenrollments will be conducted in accordance with one of the following procedures:

a. For voluntary disenrollments other than described in (c) below and for involuntary disenrollments other than those described in (b) below, Health Plan will process the disenrollment under the individual disenrollment requirements specified in the CMS Enrollment and Disenrollment Guidance.

b. For involuntary disenrollments that occur when the Group determines that a Member is no longer eligible to participate in the Group MA Plan, Group shall follow the below process, as applicable.

Group and Health Plan also agree:

i. Group will (including in cases where Health Plan or Group terminates this Agreement):

(1) Provide a prospective notice to the affected Member(s): alerting them of the termination event and describing other health plan or health insurance options that may be available through Group. This notice must be received by the member no less than twenty-one (21) days prior to the effective date of disenrollment.

(2) Provide a prospective notice of the termination event to Health Plan. This notice must be sent one hundred twenty (120) days prior to the effective date of disenrollment; and

(3) Provide Health Plan with all information necessary for Health Plan to submit a complete disenrollment request transaction to CMS.

c. Health Plan may accept a voluntary disenrollment request directly from Group without receiving an election form from each employee or retiree. Group agrees that in order to use this process:

i. Group must submit to Health Plan information that accurately reflects Group's record of the disenrollment made by each Member. Health Plan must maintain its record of information received from Group for ten (10) years or through the date of the completion of any CMS audit, whichever is later.

ii. Group and Health Plan's electronic disenrollment transactions must, at a minimum, comply with CMS electronic security policies.

iii. Health Plan's receipt date for the disenrollment request will be the date Group's record of a Member's disenrollment choice is received by Health Plan. The effective date of disenrollment cannot be prior to receipt date.

iv. Group's record of the request to disenroll must exist in a format that can be easily, accurately and quickly reproduced for later reference by each individual member, Health Plan and/or CMS, as necessary. Group shall include that record when Group sends its next weekly file to Health Plan. Health Plan shall maintain Group's record of the request to disenroll for at least ten (10) years after the effective date of the individual's disenrollment or through the date of the completion of any CMS audit, whichever is later.

d. Group agrees to retain, for a period of ten (10) years from the effective date of disenrollment, and to provide to Health Plan upon request, documents evidencing Group's adherence to the requirements set forth in this Article VII.

ARTICLE XIV - RETROACTIVITY

The Group can elect to allow for a retroactive enrollment as long as the request for enrollment of the applicant is prior to the requested effective date and the reason for the retroactive enrollment is acceptable to Health Plan. The Group will supply Health Plan with accurate and complete enrollee information, in a format mutually agreeable to the Group and Health Plan, no later than sixty (60) days after the retroactive date of coverage.

ARTICLE XV – ADDITIONS TO COVERAGE (Outside the Open Enrollment Period)

Newly eligible Members may be covered under this Agreement in accordance with the terms of this Agreement or as required by applicable law. Newly eligible Members include:

- All newly Medicare eligible retired employees and/or spouses (age 65 and over or disabled)
- Eligible plan participants of the Group with a qualifying event, who are otherwise eligible to elect coverage under this Agreement

Newly eligible members shall have coverage according to the rules for enrollment outside of the open enrollment period under the Group's retiree health benefits plan.

The Group must provide Health Plan with accurate and complete enrollee information in a format mutually agreeable to both parties. Health Plan and the Group agree to provide health care coverage effective on the first day of the month approved by CMS for each enrollment.

ARTICLE XVI – APPEALS

Group Members have the right to appeal coverage decisions made by the Health Plan. There are five (5) levels of the appeals process with specific deadlines established by CMS for a response from the party reviewing the appeal. The appeals process includes:

- Level 1 appeal made by the Member to the Health Plan, conducted by a physician employed by the Health Plan who did not make the original coverage decision and is not a subordinate of that physician.
- Level 2 appeal made by the Member to an Independent Review Organization, an independent organization hired by Medicare.
- Level 3 appeal made by the Member to an Administrative Law Judge or attorney adjudicator.
- Level 4 appeal made by either the Member or the Health Plan to the Medicare Appeals Council, part of the Federal government.
- Level 5 appeal made by either the Member or the Health Plan to a judge at the Federal District Court.

Additional details on the required timeframes associated with filing appeals and response deadlines are outlined in the Health Plan Evidence of Coverage. The parties acknowledge that CMS may change the criteria, deadlines, or the appeals process from time to time. If CMS enacts such changes that will affect this Article XVI, the parties agree to abide by the most current CMS appeals process.

ARTICLE XVII - CONFIDENTIALITY

The Group acknowledges and agrees that the Agreement contains terms and conditions that are considered trade secrets or commercial or financial information which, under Section 10002 of Title 29 of the Delaware Code would not be disclosed as a public record. Notwithstanding the foregoing, and only at the express request of the Group, Health Plan has consented to a one-time waiver of the

confidentiality of the provisions contained in this Agreement for the sole purpose that Group can publicly disclose the Agreement without redaction. The parties understand and agree that this waiver shall not constitute any course of dealing or course of performance with respect to the parties or with respect to Health Plan's trade secrets or confidential and proprietary information generally or with respect to trade secrets or confidential and proprietary information contained within any other Health Plan contracts or agreements with Group or any other governmental entity or private party. The parties agree that this one-time waiver is limited to this Agreement only and the precise terms contained within this Agreement. This provision shall survive the expiration or termination of this Agreement.

The records of Health Plan developed and maintained in conjunction with providing payments of benefits under the terms of this Agreement shall remain proprietary and confidential to Health Plan and shall not be publicly disclosed pursuant to the above paragraph of this Article. To the extent that the Group requires such information, the Group shall in every case comply with the procedures of Health Plan for obtaining such information and hold such information in the strictest confidence.

ARTICLE XVIII - RELEASE OF INFORMATION

The parties acknowledges that Members have been advised during the enrollment process that any person or entity having information relating to any illness or injury for which benefits are claimed under this Agreement may furnish to Health Plan, upon its request, any information (including copies of records) relating to the illness or injury. In addition, Health Plan may furnish similar information to other entities providing similar benefits at their request.

Health Plan may also furnish other plans or plan sponsored entities with membership and/or coverage information for the purpose of claims processing or facilitating patient care.

To the extent permitted by law, Health Plan may undertake the following actions: Health Plan may implement quality of care and medical management initiatives with CMS approval. Health Plan may review Members' medical records to evaluate care and determine if it meets professional and industry standards. Health Plan, with CMS approval, may communicate directly with Members and their providers to promote preventive care or to discuss potentially beneficial treatment options, and may solicit Member opinions through telephone and mail surveys. Health Plan, as permitted by law, may share information about Members with designated agents, including medical professionals and other health care experts.

ARTICLE XIX - PRIVACY COMPLIANCE - GROUP CUSTOMER

Member Privacy: All personally identifiable information about Members ("Protected Member Information") is subject to various statutory privacy standards, including the regulations of the Delaware Department of Insurance implementing Title V of the Gramm-Leach-Bliley Act (18 Del. Admin. C. § 904); and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and regulations adopted thereunder by the Department of Health and Human Services (45 CFR Parts 160, 162, 164). The parties will treat all such information in accordance with those standards. Health Plan may use or disclose Protected Member Information to facilitate payment, treatment and healthcare operations, or to comply with judicial process or any applicable statute or regulation.

Certification of Compliance: The Group will maintain the confidentiality of all Protected Member Information, in accordance with applicable federal, state and local laws and regulations. The Group hereby certifies its compliance with the requirements applicable to the Group, as "Plan Sponsor," to continue to receive Protected Member Information pursuant to 45 C.F.R. § 160.504(f).

Business Associate Agreements: If either party should be considered a "business associate" of either party for purposes of HIPAA, the parties will adopt an appropriate addendum to this Agreement to include the specific mandated contract clauses applicable to "business associates" under 45 C.F.R. § 164.504(e)(2).

Other Assurance: The parties further agree that they will adopt such policies and procedures, execute such written agreements, and provide such further assurances as may be required to make their activities under this Agreement compliant with any regulations of the U.S. Department of Health and Human Services adopted pursuant to HIPAA, including, without limitation, the following:

Information Safeguards	45 CFR § 164.530(c)
Standard Transactions	45 CFR Part 162
Data Security	45 CFR Part 164

ARTICLE XX - UTILIZATION MANAGEMENT

Health Plan may in certain cases allow for certain exceptions to the utilization management program provided through this Agreement, in its sole discretion, when the exceptions result in the more efficient administration of this Agreement. The exceptions may include, but are not limited to, waiver of referral requirements, waiver of authorization requirements, case management that results in the modification of benefits, and standing authorizations or referrals for certain conditions. For all other exceptions, the utilization management program (including any exceptions thereto) shall be administered as provided in the Evidence of Coverage and the internal policies and procedures of Health Plan, all in compliance with CMS regulations.

ARTICLE XXI- COMPLIANCE WITH LAW/AMENDMENT

Health Plan shall have the right for the purpose of complying with the provisions of any law or lawful order of a regulatory authority to amend this Agreement, including, without limitation, the Evidence of Coverage, any addendum and any Schedules attached hereto, or to increase, reduce or eliminate any of the benefits provided for in the Evidence of Coverage or any addendum for eligible Members enrolled under this Agreement, and each party hereby agrees to any amendment of this Agreement and/or the Evidence of Coverage which is necessary in order to accomplish such purpose.

ARTICLE XXII- NOTICES

Unless otherwise provided herein, all notices required or permitted to be sent in accordance with this Agreement may be either personally delivered or sent by regular U.S. mail or other nationally recognized overnight carrier service, to the following addresses:

To Group at:
STATE OF DELAWARE
Statewide Benefits Office
Enterprise Business Park
97 Commerce Way, Suite 201
Dover, DE 19904

To Health Plan at:
HIGHMARK BCBSD INC.
800 Delaware Avenue, Suite 900
Wilmington, DE 19801

Any party may change the address listed herein by sending notice of such change in writing to the other party in accordance with the method outlined in this Article.

ARTICLE XXIII - GOVERNING LAW/MISCELLANEOUS

The parties hereby acknowledge that this Agreement is governed by federal law. In the event that any terms or conditions contained in this Agreement are held to be invalid or unenforceable, such terms or conditions shall be severable, and the invalidity or unenforceability of those terms or conditions shall in no way affect the validity or enforceability of any other terms or conditions contained herein. The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach or violation thereof.

ARTICLE XXIV - LIMITATIONS ON LIABILITY

The Health Plan has no liability for the acts or omissions of any provider or supplier providing Covered Services. In the event that the performance of obligations or the rendering of services provided under this Agreement is delayed or rendered impractical due to circumstances not within the reasonable control of Health Plan, including, but not limited to, a major disaster, epidemic, civil insurrection or similar causes, Health Plan will make a reasonable effort to arrange for performance. Neither Health Plan nor its participating providers will incur liability or obligation for delay or failure to provide or arrange for services under such circumstance.

ARTICLE XXV - REQUIRED DISCLOSURE OF INFORMATION

The Group agrees to provide Health Plan with all information relative to eligibility waiting periods, including, but not limited to, the existence and length of any such period imposed by the Group which Health Plan deems necessary for the purposes of complying with the requirements of HIPAA and the regulations thereunder. The Group further agrees that should the Group fail to provide said information in an accurate and timely manner, it shall reimburse Health Plan for all costs (including, but not limited to, attorney fees and court costs), fines, penalties, expenses and any other monetary losses incurred by Health Plan resulting from the Group's failure to provide said information.

ARTICLE XXVI - ENTIRE AGREEMENT

This Agreement constitutes the entire agreement between the parties and supersedes all prior discussions, negotiations, agreements, and understandings, both written and oral, between Health Plan and the Group on this subject matter. No statements or representations may be used in any legal dispute regarding the terms or any exclusions or limitations hereunder unless specifically contained in this Agreement. None of the terms or provisions of the Articles of Incorporation or Bylaws of Health Plan will form a part of this Agreement or be used in any suit hereunder unless the same is set forth in full herein. No change in this Agreement shall be valid except by an amendment or addendum signed and accepted by both parties.

ARTICLE XXVII - POLICIES AND PROCEDURES

Health Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Agreement.

ARTICLE XXVIII - ASSIGNMENT

Health Plan may assign or subcontract any or all rights or obligations under this Agreement to a subsidiary or affiliate of Health Plan or any designated subcontractor.

ARTICLE XXIX - RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD PLANS

This Agreement is between the Group, on behalf of itself and its Members, and Health Plan only. Health Plan is an independent corporation operating under licenses from the Blue Cross and Blue Shield Association ("the Association"), which is a national association of independent Blue Cross and Blue Shield Plans throughout the United States. Although all of these independent Blue Cross and Blue Shield Plans operate from a license with the Association, each of them is a separate and distinct corporation. The Association allows Health Plan to use the familiar Blue Cross and Blue Shield words and symbols. Health Plan, which is entering into this Agreement, is not contracting as an agent of the national Association. Only Health Plan shall be liable to the Group for any of Health Plan's obligations under this Agreement. This paragraph does not add any obligations to this Agreement.

ARTICLE XXX – OUT-OF-AREA SERVICES – BLUE CROSS AND BLUE SHIELD MEDICARE ADVANTAGE PROGRAM – FREEDOMBLUE PPO

Health Plan has relationships with other Blue Cross and/or Blue Shield Licensees ("Host Blues") to administer the Blue Cross and Blue Shield Medicare Advantage Program outside of the geographic area Health Plan serves (referred to hereinafter as the "BCBS Medicare Advantage Program."). When Members access healthcare services outside the geographic area that Health Plan has designated as the Service Area, the claim for those services will be processed through the BCBS Medicare Advantage Program and presented to Health Plan for payment in accordance with the rules of the BCBS Medicare Advantage Program policies then in effect. The BCBS Medicare Advantage Program available to Members under this Agreement is described generally below.

Member Liability Calculation

The cost of the service, on which member liability (copayment/coinsurance) is based, will be either:

- The Medicare allowable amount for covered services, or
- The amount either Health Plan negotiates with the provider, or the Host Blue negotiates with its provider on behalf of Health Plan Members, if applicable. The amount negotiated may be either higher than, lower than, or equal to the Medicare allowable amount.

IN WITNESS WHEREOF, the parties have read this Agreement and agree to be bound by it and therefore have caused it to be executed by their duly authorized representatives.

GROUP: **STATE OF DELAWARE**
Statewide Benefits Office
Enterprise Business Park
97 Commerce Way, Suite 201
Dover, DE 19904

By: Faith L. Rentz

Title: Faith Rentz, Director, Statewide Benefits Office

Date: 09/28/2022

HIGHMARK BCBSD INC.:
800 DELAWARE AVENUE, SUITE 900
WILMINGTON, DE 19801

By: _____

Title: Alexis Miller President, Highmark Federal Markets.

Date: 9/28/22

EXHIBIT 1

PERFORMANCE GUARANTEES

EXHIBIT 1

MEDICARE ADVANTAGE PERFORMANCE GUARANTEES

Plan Administration

Terms: Vendor will perform a review of its records to determine whether each standard was met for the time period of the quarter immediately preceding the 45th day of the month following the end of a quarter (for example, April 15 for the first quarter (January 1 – March 31) of the plan year (January 1 to December 31). Quarterly results will be averaged on an annual basis and penalty payments, if any, will be made annually within six (6) months of the end of the plan year. In no instance will a measurement or penalties apply to any period less than a full quarter.

Highmark reserves the right to revise or void these measures upon discussion between Highmark and the State, and with the consent of the State, such consent not to be unreasonably withheld, in the event a public health emergency is declared affecting (i) one or more Highmark service locations that support Services under this Agreement; and/or (ii) geographic area(s) of work or residence of ten (10%) or more Members. The preceding shall apply whether a public health emergency is declared by the World Health Organization or by an agency or instrumentality of government in the relevant geographic area(s) having such authority.

Performance Guarantee	Standard	Performance Measure	Frequency of Reporting	Dollars at Risk
Implementation/Open Enrollment Each Plan Year				
Future Contract Development	Highmark will incorporate all of the minimum requirements in the RFP and any variance identified in the bid response accepted by the State for performance commitments in the first draft of the contract. The vendor cannot propose changes that are not included in the terms of the RFP or their bid offering necessitating an excessive number of drafts.		n/a	$50,000
Implementation and Account Manager Performance	Implementation manager and account executive /manager will participate in every implementation call and will be		n/a	$50,000

Performance Guarantee	Standard	Performance Measure	Frequency of Reporting	Dollars at Risk
	prepared to lead the calls, based on detailed agenda sent to team in advance.			
Maintenance of Detailed Project Plan and Adherence to Key Deadlines	Project plan must delineate due dates, responsible parties and critical linkages between tasks, as appropriate. Project plan will be updated and distributed in advance of each implementation weekly call. All key dates will be met to the extent Vendor has control and/or has notified State of risks of failure in advance of due date. State and Vendor will agree at the beginning of implementation on which deadlines are critical to program success.		n/a	$50,000
Plan Design	Systems will be updated for accurate plan designs in time for State to conduct a pre-implementation audit.		n/a	$75,000
Account Structure	Vendor will be prepared to replicate existing account structure (within CMS and Medicare Advantage Standards) and conduct a meeting with the State to review current account structure to ensure it is adequate to meet current reporting needs.		n/a	$75,000
Communication Review and Distribution	Annual CMS mandated materials and educational member journey materials, including outbound call scripts, direct mail, email and SMS text messages, related to the State of Delaware should be provided for		Ongoing	$15,000 for each occurrence to annual max of $75,000

Performance Guarantee	Standard	Performance Measure	Frequency of Reporting	Dollars at Risk
	awareness no less than 10 business days prior to designated launch date. New CMS mandates, CMS required system generated member notification letters and any non-mandated ad-hoc materials (i.e., unplanned COVID communications, data breach communications, etc.) are excluded from this requirement.			
Initial ID Card Distribution	ID cards will be distributed at least 20 days in advance of plan effective date, pending timely receipt of accurate enrollment file feed and no unforeseen natural disasters or other factors outside Highmark's control. For all members confirmed by CMS by 11/28/2022.		n/a	$75,000
Customer Service	Customer Service center will be trained and available to respond to retiree inquiries prior to the open enrollment period and will remain open and available continuously from that point on and available 8:00 a.m. to 8:00 p.m. seven days/week, EST.		n/a	$100,000
Ongoing Claim Administration/Customer Service				
Turnaround Time for Claims	Percentage of Claims Processed in 10 business days 99% within 30 calendar days.	94% within 10 business days, 99% within 30 calendar days	Monthly	$10,000 for each % below target to an annual max of $100,000

Performance Guarantee	Standard	Performance Measure	Frequency of Reporting	Dollars at Risk
	Any month impacted by delays in CMS publishing the annual provider fee schedule would be excluded from performance calculation			
Financial Payment Accuracy	Percentage of claims paid accurately (Total dollars of audited claims paid minus sum of absolute dollar value of all over/under payments divided by the total dollars of audited claims paid.)	99%	Monthly	$10,000 for each % below target to an annual max of $100,000
Telephone Response Time	Maintain an average speed of answer of 30 seconds or less from the time of selection to speak to a live representative via the IVR system to the time a live	30 seconds or less	Monthly	$5,000 for each % below target to an annual max of $75,000

Performance Guarantee	Standard	Performance Measure	Frequency of Reporting	Dollars at Risk
	person is on the line.			
Call Abandonment Rate	Calculated automatically via automatic telephone call distribution system.	2%	Monthly	$5,000 for each % below target to an annual max of $50,000
First Call Resolution	90% of calls will be closed on the same day as received	The percentage of calls closed on the same day as received.	Quarterly	$10,000 for each % below target to an annual max of $100,000
Customer Service	Customer Service Center staff will be trained and available to respond to retiree inquiries and will remain open and available 8:00 a.m. to 8:00 p.m. seven days/week, EST.	Customer Service Center staff will be trained and available to respond to retiree inquiries and will remain open and available 8:00 a.m. to 8:00 p.m. 7 days/week, EST. (Excludes: Christmas Day, Thanksgiving Day, Memorial Day, July 4, Labor Day, Easter Sunday when occurs in April,	Ongoing	$50,000

Performance Guarantee	Standard	Performance Measure	Frequency of Reporting	Dollars at Risk
		Emergency or Weather-Related Office Closings)		
Eligibility Data	97% of all eligibility will be loaded within two business days of receipt of mutually agreed upon enrollment file format containing clean data	97%	Monthly	$5,000 for each day not loaded beyond 2 days max of $75,000
ID Card Distribution (routinely throughout the plan year)	100% mailed within 10 days of enrollment approval by CMS	98%	Monthly	$5,000 for each day past target of 10 days following CMS enrollment approval (annual max of $75,000)
Member Satisfaction Survey	Positive Response Rate	85% or higher	Annually	$5000 for each % below target to an annual max of $75,000
Open Issue Resolution Time	95.0 % within 7 business days	The percentage of open inquiries from members and the SBO completed within the stated number of days from initial receipt	Quarterly	$5,000 for each % below target to an annual max of $75,000

Performance Guarantee	Standard	Performance Measure	Frequency of Reporting	Dollars at Risk
		date to resolution date.		
Reporting (See Attachment, MA *Master Report List*)	Complete and Timely Submission of accurate reports, as defined in Attachments and , MA *Master Report List*.[1]	Complete, accurate and timely submission of reports, as defined in Attachments 1a and 1b, *Master Report List*, unless agreed to in writing by the State and Vendor.	Per Attachment, MA *Master Report List*	Timeliness: $1,000 for each report received more than 7 days past the due date to an annual max of $25,000
Prior Authorizations Denials - 2nd Level Appeal Overturns	For calendar year reviews, percentage of prior authorizations denials that are overturned by the Independent Review Entity (IRE) hired by CMS to review all health plan denials.	Rate of overturn not to exceed 8% following final determinations by the IRE, including the reopening process.	Quarterly	$5,000 for each % above target to an annual max of $75,000

1 Those items listed in Attachment, MA *Master Report List*, which also appear separately on this Performance Guarantee appendix, will be excluded from this specific standard.

Performance Guarantee	Standard	Performance Measure	Frequency of Reporting	Dollars at Risk
Account Management				
Account Management Satisfaction[2]	Score of 3.0 or higher on the State's Account Management Team Survey Form.	$25,000 for each 0.25% below 3.0 rating	Quarterly	$25,000 for each 0.25% below 3.0 rating (annual max of $75,000
			Total	**$1,500,000**

2 Overall Account Management performance will be measured quarterly, and the annual performance determination will be based on the arithmetic mean of the quarterly measurements. See Attachment 1 for the Account Management Survey.

Attachment 1

Account Management Team Survey

State of Delaware, Department of Human Resources, Statewide Benefits Office

Account Management Team Survey

Medical Program: (Vendor)

FY____ _____ Quarter (_____ to _____)

Account Management Team Survey – (Vendor)

For Reporting Period:

Completed by: SBO Vendor Management Team

The Vendor Management Team of the Statewide Benefits Office is using this tool to evaluate the Account Management Team of (Vendor) that serves as a provider of health insurance services to the employees and pensioners of the State of Delaware.

Knowledge: Indicate the extent to which you agree that your Account Management Team:

	Strongly Agree 5	Agree 4	Somewhat Agree 3	Disagree 2	Strongly Disagree 1	For any "1" or "2" responses, please provide specific comments in the area below
1. Understands your benefits plan.	❒	❒	❒	❒	❒	_____
2. Understands your business needs. Meets with you to establish needs and service expectations.	❒	❒	❒	❒	❒	_____
3. Understands your service expectations. Develops a business plan that incorporates the agreed upon needs and expectations.	❒	❒	❒	❒	❒	_____
4. Displays knowledge regarding health plan benefit design, programs and services.	❒	❒	❒	❒	❒	_____
5. Clearly explains your report results.	❒	❒	❒	❒	❒	_____

Average Rating _____

Professionalism: Indicate the extent to which you agree that your Account Management Team:

	Strongly Agree 5	Agree 4	Somewhat Agree 3	Disagree 2	Strongly Disagree 1	For any "1" or "2" responses, please provide specific comments in the area below
6. Actively listens to and acknowledges your issues and concerns.	❒	❒	❒	❒	❒	
7. Provides appropriate verbal communication.	❒	❒	❒	❒	❒	
8. Provides appropriate written communication.	❒	❒	❒	❒	❒	
9. Works with you to develop a positive working relationship.	❒	❒	❒	❒	❒	

Average Rating _____

Proactive Management: Indicate the extent to which you agree that your Account Management Team:

	Strongly Agree 5	Agree 4	Somewhat Agree 3	Disagree 2	Strongly Disagree 1	For any "1" or "2" responses, please provide specific comments in the area below
10. Actively monitors your account and interacts with you in a frequency that meets your needs.	❒	❒	❒	❒	❒	
11. Communicates potential problems/issues.	❒	❒	❒	❒	❒	
12. Provides viable alternative solutions that meet your business needs.	❒	❒	❒	❒	❒	
13. Manages and understands system requirements and their effect on your business.	❒	❒	❒	❒	❒	
14. Sets realistic expectations regarding turn-around time.	❒	❒	❒	❒	❒	

Average Rating _____

Accessibility: Indicate the extent to which you agree that your Account Management Team:

	Strongly Agree 5	Agree 4	Somewhat Agree 3	Disagree 2	Strongly Disagree 1	For any "1" or "2" responses, please provide specific comments in the area below
15. Available to you on a timely basis.	❒	❒	❒	❒	❒	
16. Allocates appropriate time when meeting with you.	❒	❒	❒	❒	❒	
17. Demonstrates flexibility with regard to schedule changes.	❒	❒	❒	❒	❒	
18. Provides/communicates alternate contacts in the event of their absence.	❒	❒	❒	❒	❒	
19. Advises you of schedule limitations upon contact for meetings, conference calls, projects etc.	❒	❒	❒	❒	❒	

Average Rating _____

Responsiveness: Indicate the extent to which you agree that your Account Management Team:

	Strongly Agree 5	Agree 4	Somewhat Agree 3	Disagree 2	Strongly Disagree 1	For any "1" or "2" responses, please provide specific comments in the area below
20. Responds to your inquiries in a timely manner.	❒	❒	❒	❒	❒	
21. Provides thorough responses to your inquiries.	❒	❒	❒	❒	❒	
22. Follows-through regarding outstanding problems/issues/items.	❒	❒	❒	❒	❒	
23. Solicits the assistance of product experts when needed.	❒	❒	❒	❒	❒	

Average Rating _____

Overall Average Rating _____

Please include any other comments or suggested action steps:

Kudos:

EXHIBIT 2

MASTER REPORT LIST

EXHIBIT 2

Master Report List Medicare Advantage Plan Year 2023

HD and State/SBO

Due dates can be revised only upon mutual agreement. Reports due on weekends, holidays or on dates of emergency closure become due the next business day.

Effective January 1 2022

	Report Description	Direction	Frequency	Method	Path	Sending Contact	Receiving Contact	Due Date	SBO Storage Location
Weekly 834 Enrollment Files									
Pension Office		Pension Office to HD	Weekly	SFTP	SFTP/Pensons/Highmark/	Robin Hartnett-Sterner, Kristal Diaz	DE Inbound Team	Every Friday	N/A
NEBS (Participating Groups)		State to HD	Weekly	SFTP	STFP/PHRST/HIGHMARK/NONPAYROLL	Leighann Hinkle; Nina Figueroa	DE Inbound Team	Every Friday	N/A
Summary Load of 834 data (Pre-CMS submission balancing report)									
	number of new enrollments number of new disenrollments number of address changes number of no changes (not sent to CMS)	**HD to State / Pension**	Weekly	**TBD**		HD Enrollment Team			
CMS Transaction Reply Report (TRR)									
Pension		HD to Pension Office	Weekly	TBD	N/A	HD Enrollment Team	Kristal Diaz & Meagan Iwaskiewicz	TBD	N/A
NEBS	Post CMS submission report of enrollment submissions •Accepted Enrollments •Accepted Disenrollments •Accepted Address Changes •Rejected transactions •Any CMS initiated disenrollments (i.e.: DOD, Loss of Entitlement)	HD to State	Weekly	TBD	N/A	HD Enrollment Team	Ashley Frey; Nina Figueroa	TBD	T:\GHIP COMPLIANCE\Non State Employee Groups\Discrepancy Reports\FY2023
Weekly Age-In Files									
Pension Office		Pension Office to HD	Weekly	SFTP	SFTP/Pensons/Highmark/	Robin Hartnett-Sterner, Kristal Diaz	DE Inbound Team	Every Friday	N/A
NEBS (Participating Groups)		State to HD	Weekly	SFTP	STFP/PHRST/HIGHMARK/NONPAYROLL	Leighann Hinkle; Nina Figueroa	DE Inbound Team	Every Friday	N/A
Pension Office Opt OutReporting	Highmark will create a report that includes any members who contact Highmark wishing to opt-out of coverage	HD to Pension Office	Weekly	Secure Email		HD Enrollment Team	Pension Office	Tuesday of each week	
NEBS (Participating Groups) Opt Out Reporting	Highmark will create a report that includes any members who contact Highmark wishing to opt-out of coverage	HD to State	Weekly	Secure Email		HD Enrollment Team	SBO	Tuesday of each week	
Highmark and DHIN									
Monthly Enrollment		HD to DHIN	Monthly	secure website	/Highmark/audaciousInquiry/72.237.77.55//stpput	Highmark vendor outbound team and DE Enrollment Staff	DHIN	1st Saturday of every month	N/A
Highmark and CVS Caremark									
Weekly EGWP Activity File	EGWP Activity File includes enrollment new adds, modifications, and terminations.	HD to CVS Caremark	Weekly	Secure SFTP	N/A	Highmark vendor outbound team	PBM - Eligibility Analysis	Wednesday of each week	N/A
Quarterly EGWP Full File	EGWP Full File is a 100% accounting of the records.	HD to CVS Caremark	Quarterly	Secure FTP	N/A	Highmark vendor outbound team	PBM - Eligibility Analysis	First Month of the Quarter	
PBM Claims File		CVS Caremark to HD	Biweekly	Secure Email	N/A	PBM - Eligibility Analysis	Wendy Beck; Lisa Mantegna		N/A
Highmark and Merative									
Universal File (Enrollment aka Eligibility)		HD to Merative	Monthly	Secure Transport	N/A	Highmark vendor outbound team	Vijaya Vempati	First Sunday of each month	N/A
Summary (Claims) only		HD to Merative	Monthly	Secure FTP	N/A	Highmark vendor outbound team	Vijaya Vempati	after payment of each weekly claims invoice	N/A
Highmark and CVS Caremark									

Pre-Edit Report (**State of Delaware Pensioner** Highmark Summary Load Report)	The Summary Load Report (SLR) is a 100% accounting of the records received on client file, with processing status. It is used to determine whether there are any errors that need to be corrected in the Highmark file before Vendor sends to CMS.	PBM to Highmark	Weekly	Secure Email	N/A	PBM - Eligibility Analysis	Highmark Eligibility Team / SBO Program Lead	Wednesdays	T:\Benefit Programs\Prescription\CVS Caremark\Reports\Eligibility and Enrollment\EGWP\Summary Load Report(Pre-Edit)
Pre-Edit Report (**Non-State of Delaware Pensioner** Highmark Summary Load Report)	The Summary Load Report (SLR) is a 100% accounting of the records received on client file, with processing status. It is used to determine whether there are any errors that need to be corrected in the Highmark file before Vendor sends to CMS.	PBM to Highmark	Weekly	Secure Email	N/A	PBM - Eligibility Analysis	Highmark Eligibility Team / SBO Program Lead	Wednesdays	T:\Benefit Programs\Prescription\CVS Caremark\Reports\Eligibility and Enrollment\EGWP\Summary Load Report(Pre-Edit)
Age-in Supplemental Reporting Reconciliation (2 files)	• Age In Enrollment Process • Part C vs. Part D Enrollment Rejection Sync Process	Highmark to CVS	Monthly	SFTP-being confirmed	N/A	PBM - Eligibility Analysis	Highmark Eligibility Team / SBO Program Lead	by the 25th of each month	
Highmark Reports to the State									
Highmark SOD Concierge Call Report	Call Center statistics with top call drivers	HD to State	Weekly			HM Concierge Mgr. / Lead		Wednesday of each week	
Medicare Advantage network updates (DE only)	Updates on contracting for DE Medicare Advantage network	HD to State	Monthly	Word Document		HM MA Client Team		Monthly, within 10 days of end of the prior month	
SoD Medicare Advantage Prior Authorization Reporting	1) Total number of prior authorizations submitted, the percentage approved, the percentage of denials, in total and for defined service categories 2) Initial prior authorization decisions timing for standard and urgent/expedited requests	HD to State	Monthly	TBD		HM MA Client Team		within 45 days of the end the month	
SoD Medicare Advantage Appeals Reporting	1) Number of prior authorization denial appeals received at 1st level – 5th level appeal. 2) Percentage of appeals that are upheld or overturned at 1st level appeal – 5th level appeal.	HD to State	Quarterly	TBD		HM MA Client Team		45 days after end of the period –Q4 report will be 4 months form end of the quarter	
Medical Loss Ratio (MLR) report		HD to State	Quarterly	TBD		HM MA Client Team		(90 days after end of quarter (includes 2 months of claims run out)	
Gain Share Report	Report that calculates if the gain share payment is reached	HD to State	Annually	TBD		HM MA Client Team		within 60 days after the CMS final payment is released for a given calendar year	
Highmark Group Experience Reporting Package	Comprehensive reporting package of plan performance	HD to State	Quarterly	TBD		HM MA Client Team		(90 days after end of quarter (includes 2 months of claims run out)	
DIABETES Reporting									
HB203 Report	Required details to be defined	HD - TBD	Once every other ye	TBD		TBD			

Exhibit 3
Highmark Prior Authorization List
(Effective 10-1-2022)

Exhibit 3
Highmark Prior Authorization List
Eff. 10/1/2022

Benefit Category	CODE	TERMINOLOGY
Advanced Imaging (Radiology & Cardiology)	70450	C T Head Without Contrast
Advanced Imaging (Radiology & Cardiology)	70460	C T Head With Contrast
Advanced Imaging (Radiology & Cardiology)	70470	C T Head Without & With Contrast
Advanced Imaging (Radiology & Cardiology)	70480	C T Orbit Without Contrast
Advanced Imaging (Radiology & Cardiology)	70481	C T Orbit With Contrast
Advanced Imaging (Radiology & Cardiology)	70482	C T Orbit Without & With Contrast
Advanced Imaging (Radiology & Cardiology)	70486	C T Maxillofacial Without Contrast
Advanced Imaging (Radiology & Cardiology)	70487	C T Maxillofacial With Contrast
Advanced Imaging (Radiology & Cardiology)	70488	C T Maxillofacial Without & With Contrast
Advanced Imaging (Radiology & Cardiology)	70490	C T Soft Tissue Neck Without Contrast
Advanced Imaging (Radiology & Cardiology)	70491	C T Soft Tissue Neck With Contrast
Advanced Imaging (Radiology & Cardiology)	70492	C T Soft Tissue Neck Without & With Contrast
Advanced Imaging (Radiology & Cardiology)	70496	C T Angiography Head
Advanced Imaging (Radiology & Cardiology)	70498	C T Angiography Neck
Advanced Imaging (Radiology & Cardiology)	71250	Computed tomography, thorax, diagnostic; without contrast material
Advanced Imaging (Radiology & Cardiology)	71260	Computed tomography, thorax, diagnostic; with contrast material(s)
Advanced Imaging (Radiology & Cardiology)	71270	Computed tomography, thorax, diagnostic; without contrast material, followed by contrast material(s) and further sections
Advanced Imaging (Radiology & Cardiology)	71271	Computed tomography, thorax, low dose for lung cancer screening, without contrast material(s)
Advanced Imaging (Radiology & Cardiology)	71275	C T Angiography Chest Without Contrast Material, Followed by Contrast Material and Further Sections,Including Image Postprocessing
Advanced Imaging (Radiology & Cardiology)	72125	C T Cervical Spine Without Contrast
Advanced Imaging (Radiology & Cardiology)	72126	C T Cervical Spine With Contrast
Advanced Imaging (Radiology & Cardiology)	72127	C T Cervical Spine Without & With Contrast
Advanced Imaging (Radiology & Cardiology)	72128	C T Thoracic Spine Without Contrast
Advanced Imaging (Radiology & Cardiology)	72129	C T Thoracic Spine With Contrast
Advanced Imaging (Radiology & Cardiology)	72130	C T Thoracic Spine Without & With Contrast
Advanced Imaging (Radiology & Cardiology)	72131	C T Lumbar Spine Without Contrast
Advanced Imaging (Radiology & Cardiology)	72132	C T Lumbar Spine With Contrast
Advanced Imaging (Radiology & Cardiology)	72133	C T Lumbar Spine Without & With Contrast
Advanced Imaging (Radiology & Cardiology)	72191	C T Angiography Pelvis
Advanced Imaging (Radiology & Cardiology)	72192	C T Pelvis Without Contrast
Advanced Imaging (Radiology & Cardiology)	72193	C T Pelvis With Contrast
Advanced Imaging (Radiology & Cardiology)	72194	C T Pelvis Without & With Contrast
Advanced Imaging (Radiology & Cardiology)	73200	C T Upper Extremity Without Contrast
Advanced Imaging (Radiology & Cardiology)	73201	C T Upper Extremity With Contrast
Advanced Imaging (Radiology & Cardiology)	73202	C T Upper Extremity Without & With Contrast
Advanced Imaging (Radiology & Cardiology)	73206	C T Angiography Upper Extremity
Advanced Imaging (Radiology & Cardiology)	73700	C T Lower Extremity Without Contrast
Advanced Imaging (Radiology & Cardiology)	73701	C T Lower Extremity With Contrast
Advanced Imaging (Radiology & Cardiology)	73702	C T Lower Extremity Without & With Contrast
Advanced Imaging (Radiology & Cardiology)	73706	C T Angiography Lower Extremity
Advanced Imaging (Radiology & Cardiology)	74150	C T Abdomen Without Contrast
Advanced Imaging (Radiology & Cardiology)	74160	C T Abdomen With Contrast
Advanced Imaging (Radiology & Cardiology)	74170	C T Abdomen Without & With Contrast
Advanced Imaging (Radiology & Cardiology)	74174	CT angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing
Advanced Imaging (Radiology & Cardiology)	74175	C T Angiography Abdomen
Advanced Imaging (Radiology & Cardiology)	74176	CT Abdomen And Pelvis Without Contrast
Advanced Imaging (Radiology & Cardiology)	74177	CT Abdomen And Pelvis With Contrast
Advanced Imaging (Radiology & Cardiology)	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
Advanced Imaging (Radiology & Cardiology)	74261	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material
Advanced Imaging (Radiology & Cardiology)	74262	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed
Advanced Imaging (Radiology & Cardiology)	74263	Computed tomographic (CT) colonography, screening, including image postprocessing
Advanced Imaging (Radiology & Cardiology)	75635	C T Angiography Abdominal Aorta
Advanced Imaging (Radiology & Cardiology)	76380	C T Limited Or Localized Follow-Up Study
Advanced Imaging (Radiology & Cardiology)	76497	Unlisted computed tomography procedure
Advanced Imaging (Radiology & Cardiology)	70544	M R A Head Without Contrast
Advanced Imaging (Radiology & Cardiology)	70545	M R A Head With Contrast
Advanced Imaging (Radiology & Cardiology)	70546	M R A Head With & Without Contrast
Advanced Imaging (Radiology & Cardiology)	70547	M R A Neck Without Contrast
Advanced Imaging (Radiology & Cardiology)	70548	M R A Neck With Contrast
Advanced Imaging (Radiology & Cardiology)	70549	M R A Neck With & Without Contrast
Advanced Imaging (Radiology & Cardiology)	71555	M R A Chest (Excluding Myocardium) With Or Without Contrast
Advanced Imaging (Radiology & Cardiology)	72159	M R A Spinal Canal With Or Without Contrast
Advanced Imaging (Radiology & Cardiology)	72198	M R A Pelvis With Or Without Contrast
Advanced Imaging (Radiology & Cardiology)	73225	M R A Upper Extremity With Or Without Contrast
Advanced Imaging (Radiology & Cardiology)	73725	M R A Lower Extremity With Or Without Contrast
Advanced Imaging (Radiology & Cardiology)	74185	M R A Abdomen With Or Without Contrast
Advanced Imaging (Radiology & Cardiology)	70336	M R I T M J
Advanced Imaging (Radiology & Cardiology)	70540	M R I Orbit, Face, and/or Neck Without Contrast
Advanced Imaging (Radiology & Cardiology)	70542	M R I Face, Orbit, and/or Neck With Contrast
Advanced Imaging (Radiology & Cardiology)	70543	M R I Face, Orbit, and/or Neck With & Without Contrast

**Select new-to-market drugs with not otherwise classified (NOC) HCPCS codes (e.g. J3490, J3590, J9999, C9399) will require prior authorization, pending unique HCPCS assignment by CMS

Advanced Imaging (Radiology & Cardiology)	70551	M R I Head Without Contrast
Advanced Imaging (Radiology & Cardiology)	70552	M R I Head With Contrast
Advanced Imaging (Radiology & Cardiology)	70553	M R I Head With & Without Contrast
Advanced Imaging (Radiology & Cardiology)	70554	MRI Brain, functional MRI
Advanced Imaging (Radiology & Cardiology)	70555	MRI Brain, functional MRI, requiring physician
Advanced Imaging (Radiology & Cardiology)	71550	M R I Chest Without Contrast
Advanced Imaging (Radiology & Cardiology)	71551	M R I Chest With Contrast
Advanced Imaging (Radiology & Cardiology)	71552	M R I Chest With & Without Contrast
Advanced Imaging (Radiology & Cardiology)	72141	M R I Cervical Spine Without Contrast
Advanced Imaging (Radiology & Cardiology)	72142	M R I Cervical Spine With Contrast
Advanced Imaging (Radiology & Cardiology)	72146	M R I Thoracic Spine Without Contrast
Advanced Imaging (Radiology & Cardiology)	72147	M R I Thoracic Spine With Contrast
Advanced Imaging (Radiology & Cardiology)	72148	M R I Lumbar Spine Without Contrast
Advanced Imaging (Radiology & Cardiology)	72149	M R I Lumbar Spine With Contrast
Advanced Imaging (Radiology & Cardiology)	72156	M R I Cervical Spine With & Without Contrast
Advanced Imaging (Radiology & Cardiology)	72157	M R I Thoracic Spine With & Without Contrast
Advanced Imaging (Radiology & Cardiology)	72158	M R I Lumbar Spine With & Without Contrast
Advanced Imaging (Radiology & Cardiology)	72195	M R I Pelvis Without Contrast
Advanced Imaging (Radiology & Cardiology)	72196	M R I Pelvis With Contrast
Advanced Imaging (Radiology & Cardiology)	72197	M R I Pelvis With & Without Contrast
Advanced Imaging (Radiology & Cardiology)	73218	M R I Upper Extremity Without Contrast
Advanced Imaging (Radiology & Cardiology)	73219	M R I Upper Extremity With Contrast
Advanced Imaging (Radiology & Cardiology)	73220	M R I Upper Extremity With & Without Contrast
Advanced Imaging (Radiology & Cardiology)	73221	M R I Upper Extremity Joint Without Contrast
Advanced Imaging (Radiology & Cardiology)	73222	M R I Upper Extremity Joint With Contrast
Advanced Imaging (Radiology & Cardiology)	73223	M R I Upper Extremity Joint With & Without Contrast
Advanced Imaging (Radiology & Cardiology)	73718	M R I Lower Extremity Without Contrast
Advanced Imaging (Radiology & Cardiology)	73719	M R I Lower Extremity With Contrast
Advanced Imaging (Radiology & Cardiology)	73720	M R I Lower Extremity With & Without Contrast
Advanced Imaging (Radiology & Cardiology)	73721	M R I Lower Extremity Joint Without Contrast
Advanced Imaging (Radiology & Cardiology)	73722	M R I Lower Extremity Joint With Contrast
Advanced Imaging (Radiology & Cardiology)	73723	M R I Lower Extremity Joint With & Without Contrast
Advanced Imaging (Radiology & Cardiology)	74181	M R I Abdomen Without Contrast
Advanced Imaging (Radiology & Cardiology)	74182	M R I Abdomen With Contrast
Advanced Imaging (Radiology & Cardiology)	74183	M R I Abdomen With & Without Contrast
Advanced Imaging (Radiology & Cardiology)	74712	Magnetic resonance (eg, proton) imaging, fetal, including placental and maternal pelvic imaging when performed; single or first gestation
Advanced Imaging (Radiology & Cardiology)	74713	Magnetic resonance (eg, proton) imaging, fetal, including placental and maternal pelvic imaging when performed; each additional gestation (List separately in addition to code for primary procedure)
Advanced Imaging (Radiology & Cardiology)	76390	M R I Spectroscopy
Advanced Imaging (Radiology & Cardiology)	76391	Magnetic resonance (eg, vibration) elastography
Advanced Imaging (Radiology & Cardiology)	76498	Unlisted MRI Procedure
Advanced Imaging (Radiology & Cardiology)	77021	M R I Guidance For Needle Placement
Advanced Imaging (Radiology & Cardiology)	77022	Magnetic resonance guidance for, and monitoring of, parenchymal tissue ablation
Advanced Imaging (Radiology & Cardiology)	77046	Magnetic resonance imaging, breast, without contrast material; unilateral
Advanced Imaging (Radiology & Cardiology)	77047	Magnetic resonance imaging, breast, without contrast material; bilateral
Advanced Imaging (Radiology & Cardiology)	76376	3D Rendering W/O Postprocessing
Advanced Imaging (Radiology & Cardiology)	76377	3D Rendering W Postprocessing
Advanced Imaging (Radiology & Cardiology)	75571	Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium
Advanced Imaging (Radiology & Cardiology)	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)
Advanced Imaging (Radiology & Cardiology)	75573	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image postprocessing, assessment of left ventricular [LV] cardiac function, right ventricular [RV] structure and function and evaluation of vascular structures, if performed)
Advanced Imaging (Radiology & Cardiology)	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)
Advanced Imaging (Radiology & Cardiology)	75557	Cardiac magnetic resonance imaging for morphology and function without contrast material
Advanced Imaging (Radiology & Cardiology)	75559	Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging
Advanced Imaging (Radiology & Cardiology)	75561	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences
Advanced Imaging (Radiology & Cardiology)	75563	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging
Advanced Imaging (Radiology & Cardiology)	75565	Cardiac magnetic resonance imaging for velocity flow mapping (list separately in addition to code for primary procedure)
Advanced Imaging (Radiology & Cardiology)	33274	Transcatheter insertion or replacement of permanent leadless pacemaker, right ventricular, including imaging guidance (eg, fluoroscopy, venous ultrasound, ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed
Advanced Imaging (Radiology & Cardiology)	33289	Transcatheter implantation of wireless pulmonary artery pressure sensor (CardioMEMSTM) for long-term hemodynamic monitoring, including deployment and calibration of the sensor, right heart catheterization, selective pulmonary catheterization, radiological supervision and interpretation, and pulmonary artery angiography, when performed
Advanced Imaging (Radiology & Cardiology)	0042T	CT Perfusion Brain
Advanced Imaging (Radiology & Cardiology)	0331T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment;
Advanced Imaging (Radiology & Cardiology)	0332T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment; with tomographic SPECT

Advanced Imaging (Radiology & Cardiology)	0439T	Myocardial contrast perfusion echocardiography, at rest or with stress, for assessment of myocardial ischemia or viability (List separately in addition to code for primary procedure)
Advanced Imaging (Radiology & Cardiology)	0501T	Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software
Advanced Imaging (Radiology & Cardiology)	0502T	data preparation and transmission
Advanced Imaging (Radiology & Cardiology)	0503T	analysis of fluid dynamics and simulated maximal coronary hyperemia, and generation of estimated FFR model
Advanced Imaging (Radiology & Cardiology)	0504T	anatomical data review in comparison with estimated FFR model to reconcile discordant data, interpretation and report
Advanced Imaging (Radiology & Cardiology)	0515T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; complete system (includes electrode and generator [transmitter and battery])
Advanced Imaging (Radiology & Cardiology)	0516T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; electrode only
Advanced Imaging (Radiology & Cardiology)	0517T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; pulse generator component(s) (battery and/or transmitter) only
Advanced Imaging (Radiology & Cardiology)	0519T	Removal and replacement of wireless cardiac stimulator for left ventricular pacing; pulse generator component(s) (battery and/or transmitter)
Advanced Imaging (Radiology & Cardiology)	0520T	Removal and replacement of wireless cardiac stimulator for left ventricular pacing; pulse generator component(s) (battery and/or transmitter), including placement of a new electrode
Advanced Imaging (Radiology & Cardiology)	0571T	Insertion or replacement of implantable cardioverter-defibrillator system with substernal electrode(s), including all imaging guidance and electrophysiological evaluation (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters), when performed
Advanced Imaging (Radiology & Cardiology)	0572T	Insertion of substernal implantable defibrillator electrode
Advanced Imaging (Radiology & Cardiology)	0609T	Magnetic resonance spectroscopy, determination and
Advanced Imaging (Radiology & Cardiology)	0610T	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); transmission of biomarker data for software analysis
Advanced Imaging (Radiology & Cardiology)	0611T	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); postprocessing for algorithmic analysis of biomarker data for determination of relative chemical differences between discs
Advanced Imaging (Radiology & Cardiology)	0612T	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); interpretation and report
Advanced Imaging (Radiology & Cardiology)	0614T	Removal and replacement of substernal implantable defibrillator pulse generator
Advanced Imaging (Radiology & Cardiology)	0633T	Computed tomography, breast, including 3D rendering, when performed, unilateral; without contrast material
Advanced Imaging (Radiology & Cardiology)	0634T	Computed tomography, breast, including 3D rendering, when performed, unilateral; with contrast material(s)
Advanced Imaging (Radiology & Cardiology)	0635T	Computed tomography, breast, including 3D rendering, when performed, unilateral; without contrast, followed by contrast material(s)
Advanced Imaging (Radiology & Cardiology)	0636T	Computed tomography, breast, including 3D rendering, when performed, bilateral; without contrast material(s)
Advanced Imaging (Radiology & Cardiology)	0637T	Computed tomography, breast, including 3D rendering, when performed, bilateral; with contrast material(s)
Advanced Imaging (Radiology & Cardiology)	0638T	Computed tomography, breast, including 3D rendering, when performed, bilateral; without contrast, followed by contrast material(s)
Advanced Imaging (Radiology & Cardiology)	0648T	Quantitative magnetic resonance for analysis of tissue composition (e.g., fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained without diagnostic MRI examination of the same anatomy (e.g., organ, gland, tissue, target structure) during the same session.
Advanced Imaging (Radiology & Cardiology)	0649T	Quantitative magnetic resonance for analysis of tissue composition (e.g., fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained with diagnostic MRI examination of the same anatomy (e.g., organ, gland, tissue, target structure) (List separately in addition to code for primary procedure).
Advanced Imaging (Radiology & Cardiology)	0697T	Quantitative magnetic resonance for analysis of tissue composition (eg, fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained without diagnostic MRI examination of the same anatomy (eg, organ, gland, tissue, target structure) during the same session; multiple organs
Advanced Imaging (Radiology & Cardiology)	0698T	Quantitative magnetic resonance for analysis of tissue composition (eg, fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained with diagnostic MRI examination of the same anatomy (eg, organ, gland, tissue, target structure); multiple organs (List separately in addition to code for primary procedure)
Advanced Imaging (Radiology & Cardiology)	0710T	Noninvasive arterial plaque analysis using software processing of data from non-coronary computerized tomography angiography; including data preparation and transmission, quantification of the structure and composition of the vessel wall and assessment for lipid-rich necrotic core plaque to assess atherosclerotic plaque stability, data review, interpretation and report
Advanced Imaging (Radiology & Cardiology)	0711T	Noninvasive arterial plaque analysis using software processing of data from non-coronary computerized tomography angiography; data preparation and transmission
Advanced Imaging (Radiology & Cardiology)	0712T	Noninvasive arterial plaque analysis using software processing of data from non-coronary computerized tomography angiography; quantification of the structure and composition of the vessel wall and assessment for lipid-rich necrotic core plaque to assess atherosclerotic plaque stability
Advanced Imaging (Radiology & Cardiology)	0713T	Noninvasive arterial plaque analysis using software processing of data from non-coronary computerized tomography angiography; data review, interpretation and report
Advanced Imaging (Radiology & Cardiology)	33275	Transcatheter removal of permanent leadless pacemaker, right ventricular - Effective 1/1/19
Advanced Imaging (Radiology & Cardiology)	77048	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; unilateral
Advanced Imaging (Radiology & Cardiology)	77049	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; bilateral

Advanced Imaging (Radiology & Cardiology)	77078	Computed Tomography, bone mineral density study, 1 or more sites; axial skeleton
Advanced Imaging (Radiology & Cardiology)	77084	Magnetic resonance (eg, proton) imaging, bone marrow blood supply
Advanced Imaging (Radiology & Cardiology)	78012	Thyroid uptake, single or multiple quantitative measurement(s) (including stimulation, suppression, or discharge, when performed)
Advanced Imaging (Radiology & Cardiology)	78013	Thyroid imaging (including vascular flow, when performed)
Advanced Imaging (Radiology & Cardiology)	78014	Thyroid imaging (including vascular flow, when performed); with single or multiple uptake(s) quantitative measurement(s) (including stimulation, suppression, or discharge, when performed)
Advanced Imaging (Radiology & Cardiology)	78015	Thyroid Met Imaging
Advanced Imaging (Radiology & Cardiology)	78016	Thyroid Met Imaging With Additional Studies
Advanced Imaging (Radiology & Cardiology)	78018	Thyroid Scan Whole Body
Advanced Imaging (Radiology & Cardiology)	78020	Thyroid Carcinoma Metastases Uptake
Advanced Imaging (Radiology & Cardiology)	78070	Parathyroid planar imaging (including subtraction, when performed)
Advanced Imaging (Radiology & Cardiology)	78071	Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT)
Advanced Imaging (Radiology & Cardiology)	78072	Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization
Advanced Imaging (Radiology & Cardiology)	78075	Adrenal Nuclear Imaging
Advanced Imaging (Radiology & Cardiology)	78102	Bone Marrow Imaging, Limited
Advanced Imaging (Radiology & Cardiology)	78103	Bone Marrow Imaging, Multiple
Advanced Imaging (Radiology & Cardiology)	78104	Bone Marrow Imaging, Whole Body
Advanced Imaging (Radiology & Cardiology)	78140	Labeled Red Cell Sequestration
Advanced Imaging (Radiology & Cardiology)	78185	Spleen Imaging With & Without Vascular Flow
Advanced Imaging (Radiology & Cardiology)	78195	Lymph System Imaging
Advanced Imaging (Radiology & Cardiology)	78201	Liver Imaging
Advanced Imaging (Radiology & Cardiology)	78202	Liver Imaging With Flow
Advanced Imaging (Radiology & Cardiology)	78215	Liver & Spleen Imaging
Advanced Imaging (Radiology & Cardiology)	78216	Liver & Spleen Imaging With Flow
Advanced Imaging (Radiology & Cardiology)	78226	Hepatobiliary system imaging, including gallbladder when present;
Advanced Imaging (Radiology & Cardiology)	78227	Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed
Advanced Imaging (Radiology & Cardiology)	78230	Salivary Gland Imaging
Advanced Imaging (Radiology & Cardiology)	78231	Serial Salivary Gland
Advanced Imaging (Radiology & Cardiology)	78232	Salivary Gland Function Exam
Advanced Imaging (Radiology & Cardiology)	78258	Esophogus Motility Study
Advanced Imaging (Radiology & Cardiology)	78261	Gastric Mucosa Imaging
Advanced Imaging (Radiology & Cardiology)	78262	Gastroesophageal Reflux Exam
Advanced Imaging (Radiology & Cardiology)	78264	Gastric Emptying Study
Advanced Imaging (Radiology & Cardiology)	78265	Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel transit
Advanced Imaging (Radiology & Cardiology)	78266	Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel and colon transit, multiple days
Advanced Imaging (Radiology & Cardiology)	78278	GI Bleeder Scan
Advanced Imaging (Radiology & Cardiology)	78290	Meckels Diverticulum Imaging
Advanced Imaging (Radiology & Cardiology)	78291	Leveen Shunt Patency Exam
Advanced Imaging (Radiology & Cardiology)	78300	Bone Or Joint Imaging Limited
Advanced Imaging (Radiology & Cardiology)	78305	Bone Or Joint Imaging Multiple
Advanced Imaging (Radiology & Cardiology)	78306	Bone Scan Whole Body
Advanced Imaging (Radiology & Cardiology)	78315	Bone Scan 3 Phase Study
Advanced Imaging (Radiology & Cardiology)	78414	Non-Imaging Heart Function
Advanced Imaging (Radiology & Cardiology)	78428	Cardiac Shunt Imaging
Advanced Imaging (Radiology & Cardiology)	78429	Myocardial imaging, positron emission tomography (PET), metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), single study; with concurrently acquired computed tomography transmission scan
Advanced Imaging (Radiology & Cardiology)	78430	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); single study, at rest or stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan
Advanced Imaging (Radiology & Cardiology)	78431	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan
Advanced Imaging (Radiology & Cardiology)	78432	Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability);
Advanced Imaging (Radiology & Cardiology)	78433	Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability); with concurrently acquired computed tomography transmission scan
Advanced Imaging (Radiology & Cardiology)	78434	Absolute quantitation of myocardial blood flow (AQMBF), positron emission tomography (PET), rest and pharmacologic stress (List separately in addition to code for primary procedure)
Advanced Imaging (Radiology & Cardiology)	78445	Radionuclide Venogram Non-Cardiac
Advanced Imaging (Radiology & Cardiology)	78451	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)
Advanced Imaging (Radiology & Cardiology)	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
Advanced Imaging (Radiology & Cardiology)	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)
Advanced Imaging (Radiology & Cardiology)	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 redistribution and/or rest reinjection
Advanced Imaging (Radiology & Cardiology)	78456	Acute Venous Thrombosis Imaging

Advanced Imaging (Radiology & Cardiology)	78457	Venous Thrombosis Imaging Unilateral
Advanced Imaging (Radiology & Cardiology)	78458	Venous Thrombosis Images, Bilateral
Advanced Imaging (Radiology & Cardiology)	78459	Myocardial imaging, positron emission tomography (PET), metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), single study
Advanced Imaging (Radiology & Cardiology)	78466	Myocardial Infarction Scan
Advanced Imaging (Radiology & Cardiology)	78468	Heart Infarct Image Ejection Fraction
Advanced Imaging (Radiology & Cardiology)	78469	Heart Infarct Image 3D SPECT
Advanced Imaging (Radiology & Cardiology)	78472	Cardiac Bloodpool Img, Single
Advanced Imaging (Radiology & Cardiology)	78473	Cardiac Bloodpool Img, Multi
Advanced Imaging (Radiology & Cardiology)	78481	Heart First Pass Single
Advanced Imaging (Radiology & Cardiology)	78483	Cardiac Blood Pool Imaging -- Multiple
Advanced Imaging (Radiology & Cardiology)	78491	Myocardial imaging, positron emission tomography (PET), perfusion study(including ventricular wall motion[s] and/or ejection fraction[s], when performed); single study, at rest or stress (exercise or pharmacologic)
Advanced Imaging (Radiology & Cardiology)	78492	Myocardial imaging, positron emission tomography (PET), perfusion study(including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and/or stress (exercise or pharmacologic)
Advanced Imaging (Radiology & Cardiology)	78494	Cardiac Blood Pool Imaging , SPECT
Advanced Imaging (Radiology & Cardiology)	78496	Cardiac blood pool imaging, gated equilibrium, single study, at rest, with right ventricular ejection fraction by first pass technique (List separately in addition to code for primary procedure)
Advanced Imaging (Radiology & Cardiology)	78499	Unlisted Cardiovascular Procedure
Advanced Imaging (Radiology & Cardiology)	78579	Pulmonary ventilation imaging (eg, aerosol or gas)
Advanced Imaging (Radiology & Cardiology)	78580	Pulmonary perfusion imaging (eg, particulate)
Advanced Imaging (Radiology & Cardiology)	78582	Pulmonary ventilation (eg, aerosol or gas) and perfusion imaging
Advanced Imaging (Radiology & Cardiology)	78597	Quantitative differential pulmonary perfusion, including imaging when performed
Advanced Imaging (Radiology & Cardiology)	78598	Quantitative differential pulmonary perfusion and ventilation (eg, aerosol or gas), including imaging when performed
Advanced Imaging (Radiology & Cardiology)	78600	Brain Imaging Limited Static
Advanced Imaging (Radiology & Cardiology)	78601	Brain Limited Imaging And Flow
Advanced Imaging (Radiology & Cardiology)	78605	Brain Imaging Complete
Advanced Imaging (Radiology & Cardiology)	78606	Brain Imaging Complete With Flow
Advanced Imaging (Radiology & Cardiology)	78608	Brain Imaging, Positron Emission Tomography (PET) Metabolic Evaluation
Advanced Imaging (Radiology & Cardiology)	78609	Brain Imaging, Positron Emission Tomography (PET) Perfusion Evaluation
Advanced Imaging (Radiology & Cardiology)	78610	Brain Flow Imaging Only
Advanced Imaging (Radiology & Cardiology)	78630	Cisternogram (Cerebrospinal Fluid Flow)
Advanced Imaging (Radiology & Cardiology)	78635	Cerebrospinal Ventriculography
Advanced Imaging (Radiology & Cardiology)	78645	CSF Shunt Evaluation
Advanced Imaging (Radiology & Cardiology)	78650	C S F Leakage Detection And Localization
Advanced Imaging (Radiology & Cardiology)	78660	Radiopharmaceutical Dacryocystography
Advanced Imaging (Radiology & Cardiology)	78699	Unlisted Nuclear Medicine Procedures on the Nervous System
Advanced Imaging (Radiology & Cardiology)	78700	Kidney Imaging Morphology
Advanced Imaging (Radiology & Cardiology)	78701	Kidney Imaging With Vascular Flow
Advanced Imaging (Radiology & Cardiology)	78707	Kidney Imaging With Vascular Flow & Function Single Study Without Pharmacological Intervention
Advanced Imaging (Radiology & Cardiology)	78708	Kidney Imaging Single Study With Pharmacological Intervention
Advanced Imaging (Radiology & Cardiology)	78709	Kidney Imaging - Multiple Studies Without & With Pharmacological Intervention
Advanced Imaging (Radiology & Cardiology)	78725	Kidney Function Study - Non-Imaging Radioisotopic
Advanced Imaging (Radiology & Cardiology)	78730	Urinary Bladder Residual Study
Advanced Imaging (Radiology & Cardiology)	78740	Ureteral Reflux Study
Advanced Imaging (Radiology & Cardiology)	78761	Testicular Imaging With Vascular Flow
Advanced Imaging (Radiology & Cardiology)	78800	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); planar, single limited area (includes vascular flow and blood pool imaging, when performed); planar, single (includes vascular flow and blood pool imaging, when performed); planar, single
Advanced Imaging (Radiology & Cardiology)	78801	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); planar, 2 or more mulitple areas (eg, abdomen and pelvis, head and chest), 1 or more days imaging or single area imaging over 2 or more days
Advanced Imaging (Radiology & Cardiology)	78802	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); planar, whole body, single day imaging
Advanced Imaging (Radiology & Cardiology)	78803	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT) , single area (eg, head, neck, chest, pelvis), single day imaging
Advanced Imaging (Radiology & Cardiology)	78804	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); planar, whole body, requiring 2 or more days imaging
Advanced Imaging (Radiology & Cardiology)	78811	PET Imaging; limited area
Advanced Imaging (Radiology & Cardiology)	78812	PET Imaging: skull base to mid-thigh
Advanced Imaging (Radiology & Cardiology)	78813	PET Imaging: whole body
Advanced Imaging (Radiology & Cardiology)	78814	PET With Concurrently Acquired Ct; Limited Area
Advanced Imaging (Radiology & Cardiology)	78815	PET With Concurrently Acquired Ct; Skull Base To Mid-Thigh
Advanced Imaging (Radiology & Cardiology)	78816	PET With Concurrently Acquired Ct; Whole Body
Advanced Imaging (Radiology & Cardiology)	78830	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, single area (eg, head, neck, chest, pelvis), single day imaging
Advanced Imaging (Radiology & Cardiology)	78831	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT), minimum 2 areas (eg, pelvis and knees, abdomen and pelvis), single day imaging, or single area imaging over 2 or more days

Advanced Imaging (Radiology & Cardiology)	78832	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, minimum 2 areas (eg, pelvis and knees, abdomen and pelvis), single day imaging, or single area imaging over 2 or more days
Advanced Imaging (Radiology & Cardiology)	78999	Unlisted procedure, diagnostic nuclear medicine-radiation therapy treatment planning
Advanced Imaging (Radiology & Cardiology)	93303	Transthoracic echocardiography for congenital cardiac anomalies; complete
Advanced Imaging (Radiology & Cardiology)	93304	Transthoracic echocardiography for congenital cardiac anomalies; follow-up or limited study
Advanced Imaging (Radiology & Cardiology)	93306	Echocardiography, transthoracic, real-time with image documentation (2d), includes m-mode recording, when performed, complete, with spectral doppler echocardiography, and with color flow doppler echocardiography
Advanced Imaging (Radiology & Cardiology)	93307	Echocardiography, transthoracic, real-time with image documentation (2d) with or without m-mode recording; complete
Advanced Imaging (Radiology & Cardiology)	93308	Echocardiography, transthoracic, real-time with image documentation (2d) with or without m-mode recording; follow-up or limited study
Advanced Imaging (Radiology & Cardiology)	93312	TEE 2D;Incl Probe Placement, Imaging/Interp/Report
Advanced Imaging (Radiology & Cardiology)	93313	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); placement of transesophageal probe only
Advanced Imaging (Radiology & Cardiology)	93314	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); image acquisition, interpretation and report only
Advanced Imaging (Radiology & Cardiology)	93315	Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report
Advanced Imaging (Radiology & Cardiology)	93316	Transesophageal echocardiography for congenital cardiac anomalies; placement of transesophageal probe only
Advanced Imaging (Radiology & Cardiology)	93317	Transesophageal echocardiography for congenital cardiac anomalies; image acquisition, interpretation and report only
Advanced Imaging (Radiology & Cardiology)	93319	3D echocardiographic imaging and postprocessing during transesophageal echocardiography, or during transthoracic echocardiography for congenital cardiac anomalies, for the assessment of cardiac structure(s) (eg, cardiac chambers and valves, left atrial appendage, interatrial septum, interventricular septum) and function, when performed (List separately in addition to code for echocardiographic imaging
Advanced Imaging (Radiology & Cardiology)	93320	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; complete
Advanced Imaging (Radiology & Cardiology)	93321	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; follow-up or limited study
Advanced Imaging (Radiology & Cardiology)	93325	Doppler echocardiography color flow velocity mapping
Advanced Imaging (Radiology & Cardiology)	93350	Echocardiography, transthoracic, real-time with image documentation (2d), with or without m-mode recording, during rest and cardiovascular stress test, with interpretation and report
Advanced Imaging (Radiology & Cardiology)	93351	Echocardiography, transthoracic, real-time with image documentation (2d), includes m-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation
Advanced Imaging (Radiology & Cardiology)	93352	Use of echocardiographic contrast agent during stress echocardiography (list separately in addition to code for primary procedure)
Advanced Imaging (Radiology & Cardiology)	93356	Myocardial strain imaging using speckle tracking-derived assessment of myocardial mechanics (List separately in addition to codes for echocardiography imaging)
Advanced Imaging (Radiology & Cardiology)	93451	Right Heart Catheterization Including Measurement(S) Of Oxygen Saturation And Cardiac Output, When Performed
Advanced Imaging (Radiology & Cardiology)	93452	Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed
Advanced Imaging (Radiology & Cardiology)	93453	Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed
Advanced Imaging (Radiology & Cardiology)	93454	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation
Advanced Imaging (Radiology & Cardiology)	93455	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial venous grafts) including intraprocedural injection(s) for bypass graft angiography
Advanced Imaging (Radiology & Cardiology)	93456	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right heart catheterization
Advanced Imaging (Radiology & Cardiology)	93457	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization
Advanced Imaging (Radiology & Cardiology)	93458	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed
Advanced Imaging (Radiology & Cardiology)	93459	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography
Advanced Imaging (Radiology & Cardiology)	93460	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed
Advanced Imaging (Radiology & Cardiology)	93461	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography
Advanced Imaging (Radiology & Cardiology)	93462	Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (list separately in addition to code for primary procedure)

Advanced Imaging (Radiology & Cardiology)	93593	Right heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone; normal native connections
Advanced Imaging (Radiology & Cardiology)	93594	Right heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone; abnormal native connections
Advanced Imaging (Radiology & Cardiology)	93595	Left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone, normal or abnormal native connections
Advanced Imaging (Radiology & Cardiology)	93596	Right and left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone(s); normal native connections
Advanced Imaging (Radiology & Cardiology)	93597	Right and left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone(s); abnormal native connections
Advanced Imaging (Radiology & Cardiology)	C8900	MRA Abdomen with contrast
Advanced Imaging (Radiology & Cardiology)	C8901	MRA Abdomen without contrast
Advanced Imaging (Radiology & Cardiology)	C8902	MRA Abdomen with and w/o contrast
Advanced Imaging (Radiology & Cardiology)	C8903	MRI Breast w/ contrast, unilateral
Advanced Imaging (Radiology & Cardiology)	C8905	MRI Breast w. and w/o contrast, unilateral
Advanced Imaging (Radiology & Cardiology)	C8906	MRI Breast Bilateral W/ Contrast
Advanced Imaging (Radiology & Cardiology)	C8908	MRI Breast Bilateral W/ And W/O Contrast
Advanced Imaging (Radiology & Cardiology)	C8909	MRA chest w/contrast (excluding myocardium)
Advanced Imaging (Radiology & Cardiology)	C8910	MRA chest w/o contrast (excluding myocardium)
Advanced Imaging (Radiology & Cardiology)	C8911	MRA chest w/ and w/o contrast (excluding myocardium)
Advanced Imaging (Radiology & Cardiology)	C8912	MRA lower extremity w/ contrast
Advanced Imaging (Radiology & Cardiology)	C8913	MRA lower extremity w/o contrast
Advanced Imaging (Radiology & Cardiology)	C8914	MRA lower extremity w/ and w/o contrast
Advanced Imaging (Radiology & Cardiology)	C8918	MRA pelvis w/ contrast
Advanced Imaging (Radiology & Cardiology)	C8919	MRA pelvis w/o contrast
Advanced Imaging (Radiology & Cardiology)	C8920	MRA pelvis w/ and w/o contrast
Advanced Imaging (Radiology & Cardiology)	C8921	Transthoracic echocardiography w/contrast for congenital cardiac anomalies; complete
Advanced Imaging (Radiology & Cardiology)	C8922	Transthoracic echocardiography w/contrast for congenital cardiac anomalies; f/u or limited study
Advanced Imaging (Radiology & Cardiology)	C8923	Transthoracic echocardiography w/contrast, real-time w/image documentation (2d), w/wo m-mode recording; complete
Advanced Imaging (Radiology & Cardiology)	C8924	Transthoracic echocardiography w/contrast, real-time w/image documentation (2d), w/wo m-mode recording; f/u or limited study
Advanced Imaging (Radiology & Cardiology)	C8925	Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report
Advanced Imaging (Radiology & Cardiology)	C8926	Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report
Advanced Imaging (Radiology & Cardiology)	C8928	Transthoracic echocardiography w/contrast, real-time w/image documentation (2d), w/wo m-mode recording, during rest and cardiovascular stress test, w/interpretation and report
Advanced Imaging (Radiology & Cardiology)	C8929	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2d), includes m-mode recording, when performed, complete, with spectral doppler echocardiography, and with color flow doppler echocardiography
Advanced Imaging (Radiology & Cardiology)	C8930	Transthoracic echocardiography, with contrast, or without contrast followed by with contrast, real-time with image documentation (2d), includes m-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision
Advanced Imaging (Radiology & Cardiology)	C8931	MRA, W/ Dye, Spinal Canal
Advanced Imaging (Radiology & Cardiology)	C8932	MRA, W/O Dye, Spinal Canal
Advanced Imaging (Radiology & Cardiology)	C8933	MRA, W/O & W/ Dye, Spinal Canal
Advanced Imaging (Radiology & Cardiology)	C8934	MRA, W/ Dye, Upper Extremity
Advanced Imaging (Radiology & Cardiology)	C8935	MRA, W/O Dye, Upper Extr
Advanced Imaging (Radiology & Cardiology)	C8936	MRA, W/O & W/ Dye, Upper Extr
Advanced Imaging (Radiology & Cardiology)	C9762	Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with strain imaging
Advanced Imaging (Radiology & Cardiology)	C9763	Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with stress imaging
Advanced Imaging (Radiology & Cardiology)	G0219	PET Imaging Whole Body; Melanoma For Non-Covered Indications
Advanced Imaging (Radiology & Cardiology)	G0235	PET Imaging, Any Site, Not Otherwise Specified
Advanced Imaging (Radiology & Cardiology)	G0252	PET Imaging, Full And Partial-Ring Pet Scanners Only For Initial Diagnosis Of Breast Cancer And/Or Surgical Planning For Breast Cancer
Advanced Imaging (Radiology & Cardiology)	S8037	Magnetic resonance cholangiopancreato-graphy (MRCP)
Advanced Imaging (Radiology & Cardiology)	S8042	Magnetic Resonance Imaging (MRI), Low-Field
Advanced Imaging (Radiology & Cardiology)	S8085	Fluorine-18 Fluorodeoxyglucose (F-18 Fdg) Imaging Using Dual Head Coincidence Detection System. (Non-Dedicated Pet Scan)
Advanced Imaging (Radiology & Cardiology)	S8092	Electron Beam Computed Tomography (Also Known As Ultrafast CT, CINET)
Advanced Laboratory Testing (Laboratory Management)	81162	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis and full duplication/deletion analysis (ie, detection of large gene rearrangements
Advanced Laboratory Testing (Laboratory Management)	81163	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis
Advanced Laboratory Testing (Laboratory Management)	81164	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (ie, detection of large gene rearrangements)
Advanced Laboratory Testing (Laboratory Management)	81165	BRCA1 (BRCA1, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis
Advanced Laboratory Testing (Laboratory Management)	81166	BRCA1 (BRCA1, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full duplication/deletion anlaysis (ie, detection of large gene rearrangements)
Advanced Laboratory Testing (Laboratory Management)	81167	BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (ie, detection of large gene rearrangements)

Advanced Laboratory Testing (Laboratory Management)	81173	AR (androgen receptor) (eg, spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation) gene analysis; full gene sequence
Advanced Laboratory Testing (Laboratory Management)	81174	AR (androgen receptor) (eg, spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation) gene analysis; known familial variant
Advanced Laboratory Testing (Laboratory Management)	81185	CACNA1A (calcium voltage-gated channel subunit alpha1 A) (eg, spinocerebellar ataxia) gene analysis; full gene sequence
Advanced Laboratory Testing (Laboratory Management)	81186	CACNA1A (calcium voltage-gated channel subunit alpha1 A) (eg, spinocerebellar ataxia) gene analysis; known familial variant
Advanced Laboratory Testing (Laboratory Management)	81189	CSTB (cystatin B) (eg, Unverricht-Lundborg disease) gene analysis; full gene sequence
Advanced Laboratory Testing (Laboratory Management)	81190	CSTB (cystatin B) (eg, Unverricht-Lundborg disease) gene analysis; known familial variant (s)
Advanced Laboratory Testing (Laboratory Management)	81201	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; full gene sequence
Advanced Laboratory Testing (Laboratory Management)	81202	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; known familial variants
Advanced Laboratory Testing (Laboratory Management)	81203	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; duplication/deletion variants
Advanced Laboratory Testing (Laboratory Management)	81212	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; 185delAG, 5385insC, 6174delT variants
Advanced Laboratory Testing (Laboratory Management)	81215	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; known familial variant
Advanced Laboratory Testing (Laboratory Management)	81216	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis
Advanced Laboratory Testing (Laboratory Management)	81217	BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; known familial variant
Advanced Laboratory Testing (Laboratory Management)	81221	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; known familial variants
Advanced Laboratory Testing (Laboratory Management)	81222	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; duplication/deletion variants
Advanced Laboratory Testing (Laboratory Management)	81223	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; full gene sequence
Advanced Laboratory Testing (Laboratory Management)	81225	CYP2C19 (cytochrome P450, family 2, subfamily C, polypeptide 19) (eg, drug metabolism), gene analysis, common variants (eg, *2,*3, *4, *8, *17)
Advanced Laboratory Testing (Laboratory Management)	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)
Advanced Laboratory Testing (Laboratory Management)	81227	CYP2C9 (cytochrome P450, family 2, subfamily C, polypeptide 9) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *5, *6)
Advanced Laboratory Testing (Laboratory Management)	81228	Cytogenomic constitutional (genome-wide) microarray analysis; interrogation of genomic regions for copy number variants (eg, bacterial artificial chromosome [BAC] or oligo-based comparative genomic hybridization [CGH] microarray analysis)
Advanced Laboratory Testing (Laboratory Management)	81229	Cytogenomic constitutional (genome-wide) microarray analysis; interrogation of genomic regions for copy number and single nucleotide polymorphism (SNP) variants for chromosomal abnormalities
Advanced Laboratory Testing (Laboratory Management)	81230	CYP3A4 (cytochrome P450 family 3 subfamily A member 4) (eg, drug metabolism), gene analysis, common variant(s) (eg, *2, *22)
Advanced Laboratory Testing (Laboratory Management)	81231	CYP3A5 (cytochrome P450 family 3 subfamily A member 5) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4,*5, *6, *7)
Advanced Laboratory Testing (Laboratory Management)	81232	DPYD (dihydropyrimidine dehydrogenase) (eg, 5-fluorouracil/5-FU and capecitabine drug metabolism), gene analysis, common variant(s) (eg, *2A, *4, *5, *6)
Advanced Laboratory Testing (Laboratory Management)	81238	F9 (coagulation factor IX) (eg, hemophilia B), full gene sequence
Advanced Laboratory Testing (Laboratory Management)	81248	G6PD (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice), gene analysis; known familial variant(s)
Advanced Laboratory Testing (Laboratory Management)	81249	G6PD (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice), gene analysis; full gene sequence
Advanced Laboratory Testing (Laboratory Management)	81252	GJB2 (gap junction protein, beta 2, 26kDa, connexin 26) (eg, nonsyndromic hearing loss) gene analysis; full gene sequence
Advanced Laboratory Testing (Laboratory Management)	81253	GJB2 (gap junction protein, beta 2, 26kDa, connexin 26) (eg, nonsyndromic hearing loss) gene analysis; known familial variants
Advanced Laboratory Testing (Laboratory Management)	81257	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; common deletions or variant (eg, Southeast Asian, Thai, Filipino, Mediterranean, alpha3.7, alpha4.2, alpha20.5, Constant Spring)
Advanced Laboratory Testing (Laboratory Management)	81258	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; known familial variant
Advanced Laboratory Testing (Laboratory Management)	81259	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; full gene sequence
Advanced Laboratory Testing (Laboratory Management)	81269	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; duplication/deletion variants
Advanced Laboratory Testing (Laboratory Management)	81277	Cytogenomic neoplasia (genome-wide) microarray analysis, interrogation of genomic regions for copy number and loss-of- heterozygosity variants for chromosomal abnormalities
Advanced Laboratory Testing (Laboratory Management)	81283	IFNL3 (interferon, lambda 3) (eg, drug response), gene analysis, rs12979860 variant
Advanced Laboratory Testing (Laboratory Management)	81286	FXN (frataxin) (eg, Friedreich ataxia) gene analysis; full gene sequence
Advanced Laboratory Testing (Laboratory Management)	81289	FXN (frataxin) (eg, Friedreich ataxia) gene analysis; known familial variant (s)
Advanced Laboratory Testing (Laboratory Management)	81291	MTHFR (5,10-methylenetetrahydrofolate reductase) (eg, hereditary hypercoagulability) gene analysis, common variants (eg, 677T, 1298C)

Advanced Laboratory Testing (Laboratory Management)	81292	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis
Advanced Laboratory Testing (Laboratory Management)	81293	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants
Advanced Laboratory Testing (Laboratory Management)	81294	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants
Advanced Laboratory Testing (Laboratory Management)	81295	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis
Advanced Laboratory Testing (Laboratory Management)	81296	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants
Advanced Laboratory Testing (Laboratory Management)	81297	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants
Advanced Laboratory Testing (Laboratory Management)	81298	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis
Advanced Laboratory Testing (Laboratory Management)	81299	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants
Advanced Laboratory Testing (Laboratory Management)	81300	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants
Advanced Laboratory Testing (Laboratory Management)	81302	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; full sequence analysis
Advanced Laboratory Testing (Laboratory Management)	81303	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; known familial variant
Advanced Laboratory Testing (Laboratory Management)	81304	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; duplication/deletion variants
Advanced Laboratory Testing (Laboratory Management)	81306	NUDT15 (nudix hydrolase 15) (eg, drug metabolism) gene analysis, common variant(s) (eg, *2, *3, *4, *5, *6)
Advanced Laboratory Testing (Laboratory Management)	81307	PALB2 (partner and localizer of BRCA2) (eg, breast and pancreatic cancer) gene analysis; full gene sequence
Advanced Laboratory Testing (Laboratory Management)	81308	PALB2 (partner and localizer of BRCA2) (eg, breast and pancreatic cancer) gene analysis; known familial variant
Advanced Laboratory Testing (Laboratory Management)	81313	PCA3/KLK3 (prostate cancer antigen 3 [non-protein coding]/kallikrein-related peptidase 3 [prostate specific antigen]) ratio (eg, prostate cancer)
Advanced Laboratory Testing (Laboratory Management)	81317	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis
Advanced Laboratory Testing (Laboratory Management)	81318	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants
Advanced Laboratory Testing (Laboratory Management)	81319	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants
Advanced Laboratory Testing (Laboratory Management)	81321	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; full sequence analysis
Advanced Laboratory Testing (Laboratory Management)	81322	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; known familial variant
Advanced Laboratory Testing (Laboratory Management)	81323	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; duplication/deletion variant
Advanced Laboratory Testing (Laboratory Management)	81325	PMP22 (peripheral myelin protein 22) (eg, Charcot-Marie-Tooth, hereditary neuropathy with liability to pressure palsies) gene analysis; full sequence analysis
Advanced Laboratory Testing (Laboratory Management)	81326	PMP22 (peripheral myelin protein 22) (eg, Charcot-Marie-Tooth, hereditary neuropathy with liability to pressure palsies) gene analysis; known familial variant
Advanced Laboratory Testing (Laboratory Management)	81327	SEPT9 (Septin9) (eg, colorectal cancer) promoter methylation analysis
Advanced Laboratory Testing (Laboratory Management)	81335	TPMT (thiopurine S-methyltransferase) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3)
Advanced Laboratory Testing (Laboratory Management)	81336	SMN1 (survival of motor neuron 1, telomeric) (eg, spinal muscular atrophy) gene analysis; full gene sequence
Advanced Laboratory Testing (Laboratory Management)	81337	SMN1 (survival of motor neuron 1, telomeric) (eg, spinal muscular atrophy) gene analysis; known familial sequence variant(s)
Advanced Laboratory Testing (Laboratory Management)	81346	TYMS (thymidylate synthetase) (eg, 5-fluorouracil/5-FU drug metabolism), gene analysis, common variant(s) (eg, tandem repeat variant)
Advanced Laboratory Testing (Laboratory Management)	81349	Cytogenomic (genome-wide) analysis for constitutional chromosomal abnormalities; interrogation of genomic regions for copy number and loss-of-heterozygosity variants, low-pass sequencing analysis
Advanced Laboratory Testing (Laboratory Management)	81350	UGT1A1 (UDP glucuronosyltransferase 1 family, polypeptide A1) (eg, drug metabolism, hereditary unconjugated hyperbilirubinemia [Gilbert syndrome]) gene analysis, common variants (eg, *28, *36, *37)
Advanced Laboratory Testing (Laboratory Management)	81351	TP53 (tumor protein 53) (eg, Li-Fraumeni syndrome) gene analysis; full gene sequence
Advanced Laboratory Testing (Laboratory Management)	81353	TP53 (tumor protein 53) (eg, Li-Fraumeni syndrome) gene analysis; known familial variant
Advanced Laboratory Testing (Laboratory Management)	81355	VKORC1 (vitamin K epoxide reductase complex, subunit 1) (eg, warfarin metabolism), gene analysis, common variant(s) (eg, - 1639G>A, c.173+1000C>T)
Advanced Laboratory Testing (Laboratory Management)	81361	HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); common variant(s) (eg, HbS, HbC, HbE)
Advanced Laboratory Testing (Laboratory Management)	81362	HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); known familial variant(s)
Advanced Laboratory Testing (Laboratory Management)	81363	HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); duplication/deletion variant(s)
Advanced Laboratory Testing (Laboratory Management)	81364	HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); full gene sequence
Advanced Laboratory Testing (Laboratory Management)	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)

Advanced Laboratory Testing (Laboratory Management)	81401	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)
Advanced Laboratory Testing (Laboratory Management)	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 of 1 exon, loss of heterozygosity [LOH], uniparental disomy [UPD])
Advanced Laboratory Testing (Laboratory Management)	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)
Advanced Laboratory Testing (Laboratory Management)	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)
Advanced Laboratory Testing (Laboratory Management)	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, regionally targeted cytogenomic array analysis)
Advanced Laboratory Testing (Laboratory Management)	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)
Advanced Laboratory Testing (Laboratory Management)	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)
Advanced Laboratory Testing (Laboratory Management)	81408	Molecular pathology procedure, Level 9 (eg, analysis of >50 exons in a single gene by DNA sequence analysis)
Advanced Laboratory Testing (Laboratory Management)	81410	Aortic dysfunction or dilation (eg, Marfan syndrome, Loeys Dietz syndrome, Ehler Danlos syndrome type IV, arterial tortuosity syndrome); genomic sequence analysis panel, must include sequencing of at least 9 genes, including FBN1, TGFBR1, TGFBR2, COL3A1, MYH11, ACTA2, SLC2A10, SMAD3, and MYLK
Advanced Laboratory Testing (Laboratory Management)	81411	Aortic dysfunction or dilation (eg, Marfan syndrome, Loeys Dietz syndrome, Ehler Danlos syndrome type IV, arterial tortuosity syndrome); duplication/deletion analysis panel, must include analyses for TGFBR1, TGFBR2, MYH11, and COL3A1
Advanced Laboratory Testing (Laboratory Management)	81412	Ashkenazi Jewish associated disorders (eg, Bloom syndrome, Canavan disease, cystic fibrosis, familial dysautonomia, Fanconi anemia group C, Gaucher disease, Tay-Sachs disease), genomic sequence analysis panel, must include sequencing of at least 9 genes, including ASPA, BLM, CFTR, FANCC, GBA, HEXA, IKBKAP, MCOLN1, and SMPD1
Advanced Laboratory Testing (Laboratory Management)	81413	Cardiac ion channelopathies (eg, Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia); genomic sequence analysis panel, must include sequencing of at least 10 genes, including ANK2, CASQ2, CAV3, KCNE1, KCNE2, KCNH2, KCNJ2, KCNQ1, RYR2, and SCN5A
Advanced Laboratory Testing (Laboratory Management)	81414	Cardiac ion channelopathies (eg, Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia); duplication/deletion gene analysis panel, must include analysis of at least 2 genes, including KCNH2 and KCNQ1
Advanced Laboratory Testing (Laboratory Management)	81415	Exome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis
Advanced Laboratory Testing (Laboratory Management)	81416	Exome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis, each comparator exome (eg, parents, siblings) (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	81417	Exome (eg, unexplained constitutional or heritable disorder or syndrome); re-evaluation of previously obtained exome sequence (eg, updated knowledge or unrelated condition/syndrome)
Advanced Laboratory Testing (Laboratory Management)	81419	Epilepsy genomic sequence analysis panel, must include analyses for ALDH7A1, CACNA1A, CDKL5, CHD2, GABRG2, GRIN2A, KCNQ2, MECP2, PCDH19, POLG, PRRT2, SCN1A, SCN1B, SCN2A, SCN8A, SLC2A1, SLC9A6, STXBP1, SYNGAP1, TCF4, TPP1, TSC1, TSC2, and ZEB2
Advanced Laboratory Testing (Laboratory Management)	81422	Fetal chromosomal microdeletion(s) genomic sequence analysis (eg, DiGeorge syndrome, Cri-du-chat syndrome), circulating cell- free fetal DNA in maternal blood
Advanced Laboratory Testing (Laboratory Management)	81425	Genome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis
Advanced Laboratory Testing (Laboratory Management)	81426	Genome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis, each comparator genome (eg, parents, siblings) (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	81427	Genome (eg, unexplained constitutional or heritable disorder or syndrome); re-evaluation of previously obtained genome sequence (eg, updated knowledge or unrelated condition/syndrome)
Advanced Laboratory Testing (Laboratory Management)	81430	Hearing loss (eg, nonsyndromic hearing loss, Usher syndrome, Pendred syndrome); genomic sequence analysis panel, must include sequencing of at least 60 genes, including CDH23, CLRN1, GJB2, GPR98, MTRNR1, MYO7A, MYO15A, PCDH15, OTOF, SLC26A4, TMC1, TMPRSS3, USH1C, USH1G, USH2A, and WFS1
Advanced Laboratory Testing (Laboratory Management)	81431	Hearing loss (eg, nonsyndromic hearing loss, Usher syndrome, Pendred syndrome); duplication/deletion analysis panel, must include copy number analyses for STRC and DFNB1 deletions in GJB2 and GJB6 genes
Advanced Laboratory Testing (Laboratory Management)	81432	Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer); genomic sequence analysis panel, must include sequencing of at least 10 genes, always including BRCA1, BRCA2, CDH1, MLH1, MSH2, MSH6, PALB2, PTEN, STK11, and TP53
Advanced Laboratory Testing (Laboratory Management)	81433	Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer); duplication/deletion analysis panel, must include analyses for BRCA1, BRCA2, MLH1, MSH2, and STK11
Advanced Laboratory Testing (Laboratory Management)	81434	Hereditary retinal disorders (eg, retinitis pigmentosa, Leber congenital amaurosis, cone-rod dystrophy), genomic sequence analysis panel, must include sequencing of at least 15 genes, including ABCA4, CNGA1, CRB1, EYS, PDE6A, PDE6B, PRPF31, PRPH2, RDH12, RHO, RP1, RP2, RPE65, RPGR, and USH2A
Advanced Laboratory Testing (Laboratory Management)	81435	Hereditary colon cancer disorders (eg, Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis); genomic sequence analysis panel, must include sequencing of at least 10 genes, including APC, BMPR1A, CDH1, MLH1, MSH2, MSH6, MUTYH, PTEN, SMAD4, and STK11

Advanced Laboratory Testing (Laboratory Management)	81436	Hereditary colon cancer disorders (eg, Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis); duplication/deletion analysis panel, must include analysis of at least 5 genes, including MLH1, MSH2, EPCAM, SMAD4, and STK11
Advanced Laboratory Testing (Laboratory Management)	81437	Hereditary neuroendocrine tumor disorders (eg, medullary thyroid carcinoma, parathyroid carcinoma, malignant pheochromocytoma or paraganglioma); genomic sequence analysis panel, must include sequencing of at least 6 genes, including MAX, SDHB, SDHC, SDHD, TMEM127, and VHL
Advanced Laboratory Testing (Laboratory Management)	81438	Hereditary neuroendocrine tumor disorders (eg, medullary thyroid carcinoma, parathyroid carcinoma, malignant pheochromocytoma or paraganglioma); duplication/deletion analysis panel, must include analyses for SDHB, SDHC, SDHD, and VHL
Advanced Laboratory Testing (Laboratory Management)	81439	Hereditary cardiomyopathy (eg, hypertrophic cardiomyopathy, dilated cardiomyopathy, arrhythmogenic right ventricular cardiomyopathy), genomic sequence analysis panel, must include sequencing of at least 5 cardiomyopathy-related genes (eg, DSG2, MYBPC3, MYH7, PKP2, TTN)
Advanced Laboratory Testing (Laboratory Management)	81440	Nuclear encoded mitochondrial genes (eg, neurologic or myopathic phenotypes), genomic sequence panel, must include analysis of at least 100 genes, including BCS1L, C10orf2, COQ2, COX10, DGUOK, MPV17, OPA1, PDSS2, POLG, POLG2, RRM2B, SCO1, SCO2, SLC25A4, SUCLA2, SUCLG1, TAZ, TK2, and TYMP
Advanced Laboratory Testing (Laboratory Management)	81442	Noonan spectrum disorders (eg, Noonan syndrome, cardio-facio-cutaneous syndrome, Costello syndrome, LEOPARD syndrome, Noonan-like syndrome), genomic sequence analysis panel, must include sequencing of at least 12 genes, including BRAF, CBL, HRAS, KRAS, MAP2K1, MAP2K2, NRAS, PTPN11, RAF1, RIT1, SHOC2, and SOS1
Advanced Laboratory Testing (Laboratory Management)	81443	Genetic testing for severe inherited conditions (eg, cystic fibrosis, Ashkenazi Jewish-associated disorders [eg, Bloom syndrome, Canavan disease, Fanconi anemia type C, mucolipidosis type VI, Gaucher disease, Tay-Sachs disease], beta hemoglobinopathies, phenylketonuria, galactosemia), genomic sequence analysis panel, must include sequencing of at least 15 genes (eg, ACADM, ARSA, ASPA, ATP7B, BCKDHA, BCKDHB, BLM, CFTR, DHCR7, FANCC, G6PC, GAA, GALT, GBA, GBE1, HBB, HEXA, IKBKAP, MCOLN1, PAH)
Advanced Laboratory Testing (Laboratory Management)	81445	Targeted genomic sequence analysis panel, solid organ neoplasm, DNA analysis, and RNA analysis when performed, 5-50 genes (eg, ALK, BRAF, CDKN2A, EGFR, ERBB2, KIT, KRAS, NRAS, MET, PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET), interrogation for sequence variants and copy number variants or rearrangements, if performed
Advanced Laboratory Testing (Laboratory Management)	81448	Hereditary peripheral neuropathies (eg, Charcot-Marie-Tooth, spastic paraplegia), genomic sequence analysis panel, must include sequencing of at least 5 peripheral neuropathy-related genes (eg, BSCL2, GJB1, MFN2, MPZ, REEP1, SPAST, SPG11, SPTLC1)
Advanced Laboratory Testing (Laboratory Management)	81450	Targeted genomic sequence analysis panel, hematolymphoid neoplasm or disorder, DNA analysis, and RNA analysis when performed, 5-50 genes (eg, BRAF, CEBPA, DNMT3A, EZH2, FLT3, IDH1, IDH2, JAK2, KRAS, KIT, MLL, NRAS, NPM1, NOTCH1), interrogation for sequence variants, and copy number variants or rearrangements, or isoform expression or mRNA expression levels, if performed
Advanced Laboratory Testing (Laboratory Management)	81455	Targeted genomic sequence analysis panel, solid organ or hematolymphoid neoplasm, DNA analysis, and RNA analysis when performed, 51 or greater genes (eg, ALK, BRAF, CDKN2A, CEBPA, DNMT3A, EGFR, ERBB2, EZH2, FLT3, IDH1, IDH2, JAK2, KIT, KRAS, MLL, NPM1, NRAS, MET, NOTCH1, PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET), interrogation for sequence variants and copy number variants or rearrangements, if performed
Advanced Laboratory Testing (Laboratory Management)	81460	Whole mitochondrial genome (eg, Leigh syndrome, mitochondrial encephalomyopathy, lactic acidosis, and stroke-like episodes [MELAS], myoclonic epilepsy with ragged-red fibers [MERFF], neuropathy, ataxia, and retinitis pigmentosa [NARP], Leber hereditary optic neuropathy [LHON]), genomic sequence, must include sequence analysis of entire mitochondrial genome with heteroplasmy detection
Advanced Laboratory Testing (Laboratory Management)	81465	Whole mitochondrial genome large deletion analysis panel (eg, Kearns-Sayre syndrome, chronic progressive external ophthalmoplegia), including heteroplasmy detection, if performed
Advanced Laboratory Testing (Laboratory Management)	81470	X-linked intellectual disability (XLID) (eg, syndromic and non-syndromic XLID); genomic sequence analysis panel, must include sequencing of at least 60 genes, including ARX, ATRX, CDKL5, FGD1, FMR1, HUWE1, IL1RAPL, KDM5C, L1CAM, MECP2, MED12, MID1, OCRL, RPS6KA3, and SLC16A2
Advanced Laboratory Testing (Laboratory Management)	81471	X-linked intellectual disability (XLID) (eg, syndromic and non-syndromic XLID); duplication/deletion gene analysis, must include analysis of at least 60 genes, including ARX, ATRX, CDKL5, FGD1, FMR1, HUWE1, IL1RAPL, KDM5C, L1CAM, MECP2, MED12, MID1, OCRL, RPS6KA3, and SLC16A2
Advanced Laboratory Testing (Laboratory Management)	81479	Unlisted molecular pathology procedure
Advanced Laboratory Testing (Laboratory Management)	81493	Coronary artery disease, mRNA, gene expression profiling by real-time RT-PCR of 23 genes, utilizing whole peripheral blood, algorithm reported as a risk score
Advanced Laboratory Testing (Laboratory Management)	81503	Oncology (ovarian), biochemical assays of five proteins (CA-125, apolipoprotein A1, beta-2 microglobulin, transferrin, and pre- albumin), utilizing serum, algorithm reported as a risk score
Advanced Laboratory Testing (Laboratory Management)	81504	Oncology (tissue of origin), microarray gene expression profiling of > 2000 genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as tissue similarity scores
Advanced Laboratory Testing (Laboratory Management)	81518	Oncology (breast), mRNA, gene expression profiling by real-time RT-PCR of 11 genes (7 content and 4 housekeeping), utilizing formalin-fixed paraffin- embedded tissue, algorithms reported as percentage risk for metastatic recurrence and likelihood of benefit from extended endocrine therapy
Advanced Laboratory Testing (Laboratory Management)	81519	Oncology (breast), mRNA, gene expression profiling by real-time RT-PCR of 21 genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as recurrence score
Advanced Laboratory Testing (Laboratory Management)	81520	Oncology (breast), mRNA gene expression profiling by hybrid capture of 58 genes (50 content and 8 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a recurrence risk score
Advanced Laboratory Testing (Laboratory Management)	81521	Oncology (breast), mRNA, microarray gene expression profiling of 70 content genes and 465 housekeeping genes, utilizing fresh frozen or formalin-fixed paraffin-embedded tissue, algorithm reported as index related to risk of distant metastasis
Advanced Laboratory Testing (Laboratory Management)	81522	Oncology (breast), mRNA, gene expression profiling by RT-PCR of 12 genes (8 content and 4 housekeeping), utilizing formalin- fixed paraffin-embedded tissue, algorithm reported as recurrence risk score

Advanced Laboratory Testing (Laboratory Management)	81523	Oncology (breast), mRNA, next-generation sequencing gene expression profiling of 70 content genes and 31 housekeeping genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as index related to risk to distant metastasis
Advanced Laboratory Testing (Laboratory Management)	81525	Oncology (colon), mRNA, gene expression profiling by real-time RT-PCR of 12 genes (7 content and 5 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a recurrence score
Advanced Laboratory Testing (Laboratory Management)	81529	Oncology (cutaneous melanoma), mRNA, gene expression profiling by real-time RT-PCR of 31 genes (28 content and 3 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as recurrence risk, including likelihood of sentinel lymph node metastasis
Advanced Laboratory Testing (Laboratory Management)	81535	Oncology (gynecologic), live tumor cell culture and chemotherapeutic response by DAPI stain and morphology, predictive algorithm reported as a drug response score; first single drug or drug combination
Advanced Laboratory Testing (Laboratory Management)	81536	Oncology (gynecologic), live tumor cell culture and chemotherapeutic response by DAPI stain and morphology, predictive algorithm reported as a drug response score; each additional single drug or drug combination (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	81538	Oncology (lung), mass spectrometric 8-protein signature, including amyloid A, utilizing serum, prognostic and predictive algorithm reported as good versus poor overall survival
Advanced Laboratory Testing (Laboratory Management)	81539	Oncology (high-grade prostate cancer), biochemical assay of four proteins (Total PSA, Free PSA, Intact PSA, and human kallikrein-2 [hK2]), utilizing plasma or serum, prognostic algorithm reported as a probability score
Advanced Laboratory Testing (Laboratory Management)	81541	Oncology (prostate), mRNA gene expression profiling by real-time RT-PCR of 46 genes (31 content and 15 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a disease-specific mortality risk score
Advanced Laboratory Testing (Laboratory Management)	81542	Oncology (prostate), mRNA, microarray gene expression profiling of 22 content genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as metastasis risk score
Advanced Laboratory Testing (Laboratory Management)	81546	Oncology (thyroid), mRNA, gene expression analysis of 10,196 genes, utilizing fine needle aspirate, algorithm reported as a categorical result (eg, benign or suspicious)
Advanced Laboratory Testing (Laboratory Management)	81551	Oncology (prostate), promoter methylation profiling by real-time PCR of 3 genes (GSTP1, APC, RASSF1), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a likelihood of prostate cancer detection on repeat biopsy
Advanced Laboratory Testing (Laboratory Management)	81552	Oncology (uveal melanoma), mRNA, gene expression profiling by real-time RT-PCR of 15 genes (12 content and 3 housekeeping), utilizing fine needle aspirate or formalin-fixed paraffin-embedded tissue, algorithm reported as risk of metastasis
Advanced Laboratory Testing (Laboratory Management)	81554	Pulmonary disease (idiopathic pulmonary fibrosis [IPF]), mRNA, gene expression analysis of 190 genes, utilizing transbronchial biopsies, diagnostic algorithm reported as categorical result (eg, positive or negative for high probability of usual interstitial pneumonia [UIP])
Advanced Laboratory Testing (Laboratory Management)	81595	Cardiology (heart transplant), mRNA, gene expression profiling by real-time quantitative PCR of 20 genes (11 content and 9 housekeeping), utilizing subfraction of peripheral blood, algorithm reported as a rejection risk score
Advanced Laboratory Testing (Laboratory Management)	81596	Infectious disease, chronic hepatitis C virus (HCV) infection, six biochemical assays (ALT, A2-macroglobulin, apolipoprotein A-1, total bilirubin, GGT, and haptoglobin) utilizing serum, prognostic algorithm reported as scores for fibrosis and necroinflammatory activity in liver
Advanced Laboratory Testing (Laboratory Management)	81599	Unlisted multianalyte assay with algorithmic analysis
Advanced Laboratory Testing (Laboratory Management)	84999	Unlisted chemistry procedure
Advanced Laboratory Testing (Laboratory Management)	0002M	Liver disease, ten biochemical assays (ALT, A2-macroglobulin, apolipoprotein A-1, total bilirubin, GGT, haptoglobin, AST, glucose, total cholesterol and triglycerides) utilizing serum, prognostic algorithm reported as quantitative scores for fibrosis, steatosis and alcoholic steatohepatitis (ASH)
Advanced Laboratory Testing (Laboratory Management)	0003M	Liver disease, ten biochemical assays (ALT, A2-macroglobulin, apolipoprotein A-1, total bilirubin, GGT, haptoglobin, AST, glucose, total cholesterol and triglycerides) utilizing serum, prognostic algorithm reported as quantitative scores for fibrosis, steatosis and nonalcoholic steatohepatitis (NASH)
Advanced Laboratory Testing (Laboratory Management)	0004M	Scoliosis, DNA analysis of 53 single nucleotide polymorphisms (SNPs), using saliva, prognostic algorithm reported as a risk score
Advanced Laboratory Testing (Laboratory Management)	0006M	Oncology (hepatic), mRNA expression levels of 161 genes, utilizing fresh hepatocellular carcinoma tumor tissue, with alpha- fetoprotein level, algorithm reported as a risk classifier
Advanced Laboratory Testing (Laboratory Management)	0007M	Oncology (gastrointestinal neuroendocrine tumors), real-time PCR expression analysis of 51 genes, utilizing whole peripheral blood, algorithm reported as a nomogram of tumor disease index
Advanced Laboratory Testing (Laboratory Management)	0011M	Oncology, prostate cancer, mRNA expression assay of 12 genes (10 content and 2 housekeeping), RT-PCR test utilizing blood plasma and urine, algorithms to predict high-grade prostate cancer risk
Advanced Laboratory Testing (Laboratory Management)	0012M	Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [CDK1], IGFBP5, and CXCR2), utilizing urine, algorithm reported as a risk score for having urothelial carcinoma
Advanced Laboratory Testing (Laboratory Management)	0013M	Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [CDK1], IGFBP5, and CXCR2), utilizing urine, algorithm reported as a risk score for having recurrent urothelial carcinoma
Advanced Laboratory Testing (Laboratory Management)	0016M	Oncology (bladder), mRNA, microarray gene expression profiling of 219 genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as molecular subtype (luminal, luminal infiltrated, basal, basal claudin-low, neuroendocrine-like)
Advanced Laboratory Testing (Laboratory Management)	0017M	Oncology (diffuse large B-cell lymphoma [DLBCL]), mRNA, gene expression profiling by fluorescent probe hybridization of 20 genes, formalin-fixed paraffinembedded tissue, algorithm reported as cell of origin
Advanced Laboratory Testing (Laboratory Management)	0018U	Oncology (thyroid), microRNA profiling by RT-PCR of 10 microRNA sequences, utilizing fine needle aspirate, algorithm reported as a positive or negative result for moderate to high risk of malignancy
Advanced Laboratory Testing (Laboratory Management)	0019U	Oncology, RNA, gene expression by whole transcriptome sequencing, formalin-fixed paraffin embedded tissue or fresh frozen tissue, predictive algorithm reported as potential targets for therapeutic agents

Advanced Laboratory Testing (Laboratory Management)	0022U	Targeted genomic sequence analysis panel, cholangiocarcinoma and non-small cell lung neoplasia, DNA and RNA analysis, 1-23 genes, interrogation for sequence variants and rearrangements, reported as presence/absence of variants and associated therapy(ies) to consider
Advanced Laboratory Testing (Laboratory Management)	0026U	Oncology (thyroid), DNA and mRNA of 112 genes, next-generation sequencing, fine needle aspirate of thyroid nodule, algorithmic analysis reported as a categorical result ("Positive, high probability of malignancy" or "Negative, low probability of malignancy")
Advanced Laboratory Testing (Laboratory Management)	0029U	Drug metabolism (adverse drug reactions and drug response), targeted sequence analysis (ie, CYP1A2, CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, CYP4F2, SLCO1B1, VKORC1 and rs12777823)
Advanced Laboratory Testing (Laboratory Management)	0030U	Drug metabolism (warfarin drug response), targeted sequence analysis (ie, CYP2C9, CYP4F2, VKORC1, rs12777823)
Advanced Laboratory Testing (Laboratory Management)	0036U	Exome (ie, somatic mutations), paired formalin-fixed paraffin-embedded tumor tissue and normal specimen, sequence analyses
Advanced Laboratory Testing (Laboratory Management)	0037U	Targeted genomic sequence analysis, solid organ neoplasm, DNA analysis of 324 genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability and tumor mutational burden
Advanced Laboratory Testing (Laboratory Management)	0048U	Oncology (solid organ neoplasia), DNA, targeted sequencing of protein-coding exons of 468 cancer-associated genes, including interrogation for somatic mutations and microsatellite instability, matched with normal specimens, utilizing formalin-fixed paraffin- embedded tumor tissue, report of clinically significant mutation(s)
Advanced Laboratory Testing (Laboratory Management)	0050U	Targeted genomic sequence analysis panel, acute myelogenous leukemia, DNA analysis, 194 genes, interrogation for sequence variants, copy number variants or rearrangements
Advanced Laboratory Testing (Laboratory Management)	0053U	Oncology (prostate cancer), FISH analysis of 4 genes (ASAP1, HDAC9, CHD1 and PTEN), needle biopsy specimen, algorithm reported as probability of higher tumor grade
Advanced Laboratory Testing (Laboratory Management)	0055U	Cardiology (heart transplant), cell-free DNA, PCR assay of 96 DNA target sequences (94 single nucleotide polymorphism targets and two control targets), plasma
Advanced Laboratory Testing (Laboratory Management)	0067U	Oncology (breast), immunohistochemistry, protein expression profiling of 4 biomarkers (matrix metalloproteinase-1 [MMP-1], carcinoembryonic antigen-related cell adhesion molecule 6 [CEACAM6], hyaluronoglucosaminidase [HYAL1], highly expressed in cancer protein [HEC1]), formalin-fixed paraffin-embedded precancerous breast tissue, algorithm reported as carcinoma risk score
Advanced Laboratory Testing (Laboratory Management)	0069U	Oncology (colorectal), microRNA, RT-PCR expression profiling of miR-31-3p, formalin fixed paraffin-embedded tissue, algorithm reported as an expression score
Advanced Laboratory Testing (Laboratory Management)	0070U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, common and select rare variants (ie, *2, *3, *4, *4N, *5, *6, *7, *8, *9, *10, *11, *12, *13, *14A, *14B, *15, *17, *29, *35, *36, *41, *57, *61, *63, *68, *83, *xN)
Advanced Laboratory Testing (Laboratory Management)	0071U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, full gene sequence (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	0072U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, targeted sequence analysis (ie, CYP2D6-2D7 hybrid gene) (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	0073U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, targeted sequence analysis (ie, CYP2D7-2D6 hybrid gene) (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	0074U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, targeted sequence analysis (ie, non-duplicated gene when duplication/multiplication is trans) (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	0075U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, targeted sequence analysis (ie, 5' gene duplication/multiplication) (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	0076U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, targeted sequence analysis (ie, 3' gene duplication/ multiplication) (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	0078U	Pain management (opioid-use disorder) genotyping panel, 16 common variants (ie, ABCB1, COMT, DAT1, DBH, DOR, DRD1, DRD2, DRD4, GABA, GAL, HTR2A, HTTLPR, MTHFR, MUOR, OPRK1, OPRM1), buccal swab or other germline tissue sample, algorithm reported as positive or negative risk of opioid-use disorder
Advanced Laboratory Testing (Laboratory Management)	0084U	Red blood cell antigen typing, DNA, genotyping of 10 blood groups with phenotype prediction of 37 red blood cell antigens
Advanced Laboratory Testing (Laboratory Management)	0087U	Cardiology (heart transplant), mRNA gene expression profiling by microarray of 1283 genes, transplant biopsy tissue, allograft rejection and injury algorithm reported as a probability score
Advanced Laboratory Testing (Laboratory Management)	0088U	Transplantation medicine (kidney allograft rejection), microarray gene expression profiling of 1494 genes, utilizing transplant biopsy tissue, algorithm reported as a probability score for rejection
Advanced Laboratory Testing (Laboratory Management)	0089U	Oncology (melanoma), gene expression profiling by RTqPCR, PRAME and LINC00518, superficial collection using adhesive patch(es)
Advanced Laboratory Testing (Laboratory Management)	0094U	Genome (eg, unexplained constitutional or heritable disorder or syndrome), rapid sequence analysis
Advanced Laboratory Testing (Laboratory Management)	0101U	Hereditary colon cancer disorders (eg, Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis), genomic sequence analysis panel utilizing a combination of NGS, Sanger, MLPA, and array CGH, with mRNA analytics to resolve variants of unknown significance when indicated (15 genes [sequencing and deletion/duplication], EPCAM and GREM1 [deletion/duplication only])
Advanced Laboratory Testing (Laboratory Management)	0102U	Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis panel utilizing a combination of NGS, Sanger, MLPA, and array CGH, with mRNA analytics to resolve variants of unknown significance when indicated (17 genes [sequencing and deletion/duplication])
Advanced Laboratory Testing (Laboratory Management)	0103U	Hereditary ovarian cancer (eg, hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis panel utilizing a combination of NGS, Sanger, MLPA, and array CGH, with mRNA analytics to resolve variants of unknown significance when indicated (24 genes [sequencing and deletion/duplication], EPCAM [deletion/duplication only])

Advanced Laboratory Testing (Laboratory Management)	0111U	Oncology (colon cancer), targeted KRAS (codons 12, 13, and 61) and NRAS (codons 12, 13, and 61) gene analysis utilizing formalin-fixed paraffin-embedded tissue
Advanced Laboratory Testing (Laboratory Management)	0113U	Oncology (prostate), measurement of PCA3 and TMPRSS2-ERG in urine and PSA in serum following prostatic massage, by RNA amplification and fluorescence-based detection, algorithm reported as risk score
Advanced Laboratory Testing (Laboratory Management)	0114U	Gastroenterology (Barrett's esophagus), VIM and CCNA1 methylation analysis, esophageal cells, algorithm reported as likelihood for Barrett's esophagus
Advanced Laboratory Testing (Laboratory Management)	0118U	Transplantation medicine, quantification of donor-derived cell-free DNA using whole genome next-generation sequencing, plasma, reported as percentage of donor-derived cell-free DNA in the total cell-free DNA
Advanced Laboratory Testing (Laboratory Management)	0120U	Oncology (B-cell lymphoma classification), mRNA, gene expression profiling by fluorescent probe hybridization of 58 genes (45 content and 13 housekeeping genes), formalin-fixed paraffin-embedded tissue, algorithm reported as likelihood for primary mediastinal B-cell lymphoma (PMBCL) and diffuse large B-cell lymphoma (DLBCL) with cell of origin subtyping in the latter
Advanced Laboratory Testing (Laboratory Management)	0129U	Hereditary breast cancer–related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis and deletion/duplication analysis panel (ATM, BRCA1, BRCA2, CDH1, CHEK2, PALB2, PTEN, and TP53)
Advanced Laboratory Testing (Laboratory Management)	0130U	Hereditary colon cancer disorders (eg, Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis), targeted mRNA sequence analysis panel (APC, CDH1, CHEK2, MLH1, MSH2, MSH6, MUTYH, PMS2, PTEN, and TP53) (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	0131U	Hereditary breast cancer–related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), targeted mRNA sequence analysis panel (13 genes) (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	0132U	Hereditary ovarian cancer–related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), targeted mRNA sequence analysis panel (17 genes) (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	0133U	Hereditary prostate cancer–related disorders, targeted mRNA sequence analysis panel (11 genes) (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	0134U	Hereditary pan cancer (eg, hereditary breast and ovarian cancer, hereditary endometrial cancer, hereditary colorectal cancer), targeted mRNA sequence analysis panel (18 genes) (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	0135U	Hereditary gynecological cancer (eg, hereditary breast and ovarian cancer, hereditary endometrial cancer, hereditary colorectal cancer), targeted mRNA sequence analysis panel (12 genes) (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	0136U	ATM (ataxia telangiectasia mutated) (eg, ataxia telangiectasia) mRNA sequence analysis (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	0137U	PALB2 (partner and localizer of BRCA2) (eg, breast and pancreatic cancer) mRNA sequence analysis (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	0138U	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) mRNA sequence analysis (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	0153U	Oncology (breast), mRNA, gene expression profiling by next-generation sequencing of 101 genes, utilizing formalin-fixed paraffin- embedded tissue, algorithm reported as a triple negative breast cancer clinical subtype(s) with information on immune cell involvement
Advanced Laboratory Testing (Laboratory Management)	0156U	Copy number (eg, intellectual disability, dysmorphology), sequence analysis
Advanced Laboratory Testing (Laboratory Management)	0157U	APC (APC regulator of WNT signaling pathway) (eg, familial adenomatosis polyposis [FAP]) mRNA sequence analysis (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	0158U	MLH1 (mutL homolog 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) mRNA sequence analysis (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	0159U	MSH2 (mutS homolog 2) (eg, hereditary colon cancer, Lynch syndrome) mRNA sequence analysis (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	0160U	MSH6 (mutS homolog 6) (eg, hereditary colon cancer, Lynch syndrome) mRNA sequence analysis (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	0161U	PMS2 (PMS1 homolog 2, mismatch repair system component) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) mRNA sequence analysis (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	0162U	Hereditary colon cancer (Lynch syndrome), targeted mRNA sequence analysis panel (MLH1, MSH2, MSH6, PMS2) (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	0169U	NUDT15 (nudix hydrolase 15) and TPMT (thiopurine S-methyltransferase) (eg, drug metabolism) gene analysis, common variants
Advanced Laboratory Testing (Laboratory Management)	0170U	Neurology (autism spectrum disorder [ASD]), RNA, next-generation sequencing, saliva, algorithmic analysis, and results reported as predictive probability of ASD diagnosis
Advanced Laboratory Testing (Laboratory Management)	0171U	Targeted genomic sequence analysis panel, acute myeloid leukemia, myelodysplastic syndrome, and myeloproliferative neoplasms, DNA analysis, 23 genes, interrogation for sequence variants, rearrangements and minimal residual disease, reported as presence/absence
Advanced Laboratory Testing (Laboratory Management)	0172U	Oncology (solid tumor as indicated by the label), somatic mutation analysis of BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) and analysis of homologous recombination deficiency pathways, DNA, formalin-fixed paraffin- embedded tissue, algorithm quantifying tumor genomic instability score
Advanced Laboratory Testing (Laboratory Management)	0173U	Psychiatry (ie, depression, anxiety), genomic analysis panel, includes variant analysis of 14 genes
Advanced Laboratory Testing (Laboratory Management)	0175U	Psychiatry (eg, depression, anxiety), genomic analysis panel, variant analysis of 15 genes
Advanced Laboratory Testing (Laboratory Management)	0179U	Oncology (non-small cell lung cancer), cell-free DNA, targeted sequence analysis of 23 genes (single nucleotide variations, insertions and deletions, fusions without prior knowledge of partner/breakpoint, copy number variations), with report of significant mutation(s)

Advanced Laboratory Testing (Laboratory Management)	0203U	Autoimmune (inflammatory bowel disease), mRNA, gene expression profiling by quantitative RT-PCR, 17 genes (15 target and 2 reference genes), whole blood, reported as a continuous risk score and classification of inflammatory bowel disease aggressiveness
Advanced Laboratory Testing (Laboratory Management)	0204U	Oncology (thyroid), mRNA, gene expression analysis of 593 genes (including BRAF, RAS, RET, PAX8, and NTRK) for sequence variants and rearrangements, utilizing fine needle aspirate, reported as detected or not detected
Advanced Laboratory Testing (Laboratory Management)	0205U	Ophthalmology (age-related macular degeneration), analysis of 3 gene variants (2 CFH gene, 1 ARMS2 gene), using PCR and MALDI-TOF, buccal swab, reported as positive or negative for neovascular age-related macular-degeneration risk associated with zinc supplements
Advanced Laboratory Testing (Laboratory Management)	0209U	Cytogenomic constitutional (genome-wide) analysis, interrogation of genomic regions for copy number, structural changes and areas of homozygosity for chromosomal abnormalities
Advanced Laboratory Testing (Laboratory Management)	0211U	Oncology (pan-tumor), DNA and RNA by next-generation sequencing, utilizing formalin-fixed paraffin-embedded tissue, interpretative report for single nucleotide variants, copy number alterations, tumor mutational burden, and microsatellite instability, with therapy association
Advanced Laboratory Testing (Laboratory Management)	0212U	Rare diseases (constitutional/heritable disorders), whole genome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants, proband
Advanced Laboratory Testing (Laboratory Management)	0213U	Rare diseases (constitutional/heritable disorders), whole genome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants, each comparator genome (eg, parent, sibling)
Advanced Laboratory Testing (Laboratory Management)	0214U	Rare diseases (constitutional/heritable disorders), whole exome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants, proband
Advanced Laboratory Testing (Laboratory Management)	0215U	Rare diseases (constitutional/heritable disorders), whole exome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants, each comparator exome (eg, parent, sibling)
Advanced Laboratory Testing (Laboratory Management)	0216U	Neurology (inherited ataxias), genomic DNA sequence analysis of 12 common genes including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants
Advanced Laboratory Testing (Laboratory Management)	0217U	Neurology (inherited ataxias), genomic DNA sequence analysis of 51 genes including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants
Advanced Laboratory Testing (Laboratory Management)	0218U	Neurology (muscular dystrophy), DMD gene sequence analysis, including small sequence changes, deletions, duplications, and variants in non-uniquely mappable regions, blood or saliva, identification and characterization of genetic variants
Advanced Laboratory Testing (Laboratory Management)	0220U	Oncology (breast cancer), image analysis with artificial intelligence assessment of 12 histologic and immunohistochemical features, reported as a recurrence score
Advanced Laboratory Testing (Laboratory Management)	0228U	Oncology (prostate), multianalyte molecular profile by photometric detection of macromolecules adsorbed on nanosponge array slides with machine learning, utilizing first morning voided urine, algorithm reported as likelihood of prostate cancer
Advanced Laboratory Testing (Laboratory Management)	0229U	BCAT1 (Branched chain amino acid transaminase 1) and IKZF1 (IKAROS family zinc finger 1) (eg, colorectal cancer) promoter methylation analysis
Advanced Laboratory Testing (Laboratory Management)	0230U	AR (androgen receptor) (eg, spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation), full sequence analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat (STR) expansions, mobile element insertions, and variants in non-uniquely mappable regions
Advanced Laboratory Testing (Laboratory Management)	0231U	CACNA1A (calcium voltage-gated channel subunit alpha 1A) (eg, spinocerebellar ataxia), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat (STR) gene expansions, mobile element insertions, and variants in non-uniquely mappable regions
Advanced Laboratory Testing (Laboratory Management)	0232U	CSTB (cystatin B) (eg, progressive myoclonic epilepsy type 1A, Unverricht-Lundborg disease), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat (STR) expansions, mobile element insertions, and variants in non-uniquely mappable regions
Advanced Laboratory Testing (Laboratory Management)	0233U	FXN (frataxin) (eg, Friedreich ataxia), gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat (STR) expansions, mobile element insertions, and variants in non-uniquely mappable regions
Advanced Laboratory Testing (Laboratory Management)	0234U	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions, and variants in non-uniquely mappable regions
Advanced Laboratory Testing (Laboratory Management)	0235U	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions, and variants in non-uniquely mappable regions
Advanced Laboratory Testing (Laboratory Management)	0236U	SMN1 (survival of motor neuron 1, telomeric) and SMN2 (survival of motor neuron 2, centromeric) (eg, spinal muscular atrophy) full gene analysis, including small sequence changes in exonic and intronic regions, duplications, deletions, and mobile element insertions
Advanced Laboratory Testing (Laboratory Management)	0237U	Cardiac ion channelopathies (eg, Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia), genomic sequence analysis panel including ANK2, CASQ2, CAV3, KCNE1, KCNE2, KCNH2, KCNJ2, KCNQ1, RYR2, and SCN5A, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions, and variants in non-uniquely mappable regions
Advanced Laboratory Testing (Laboratory Management)	0238U	Oncology (Lynch syndrome), genomic DNA sequence analysis of MLH1, MSH2, MSH6, PMS2, and EPCAM, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions, and variants in non-uniquely mappable regions

Advanced Laboratory Testing (Laboratory Management)	0239U	Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free DNA, analysis of 311 or more genes, interrogation for sequence variants, including substitutions, insertions, deletions, select rearrangements, and copy number variations
Advanced Laboratory Testing (Laboratory Management)	0242U	Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free circulating DNA analysis of 55-74 genes, interrogation for sequence variants, gene copy number amplifications, and gene rearrangements
Advanced Laboratory Testing (Laboratory Management)	0244U	Oncology (solid organ), DNA, comprehensive genomic profiling, 257 genes, interrogation for single-nucleotide variants, insertions/deletions, copy number alterations, gene rearrangements, tumor-mutational burden and microsatellite instability, utilizing formalin-fixed paraffin-embedded tumor tissue
Advanced Laboratory Testing (Laboratory Management)	0245U	Oncology (thyroid), mutation analysis of 10 genes and 37 RNA fusions and expression of 4 mRNA markers using next-generation sequencing, fine needle aspirate, report includes associated risk of malignancy expressed as a percentage
Advanced Laboratory Testing (Laboratory Management)	0246U	Red blood cell antigen typing, DNA, genotyping of at least 16 blood groups with phenotype prediction of at least 51 red blood cell antigens
Advanced Laboratory Testing (Laboratory Management)	0250U	Oncology (solid organ neoplasm), targeted genomic sequence DNA analysis of 505 genes, interrogation for somatic alterations (SNVs [single nucleotide variant], small insertions and deletions, one amplification, and four translocations), microsatellite instability and tumor-mutation burden
Advanced Laboratory Testing (Laboratory Management)	0252U	Fetal aneuploidy short tandem–repeat comparative analysis, fetal DNA from products of conception, reported as normal (euploidy), monosomy, trisomy, or partial deletion/duplication, mosaicism, and segmental aneuploidy
Advanced Laboratory Testing (Laboratory Management)	0253U	Reproductive medicine (endometrial receptivity analysis), RNA gene expression profile, 238 genes by next-generation sequencing, endometrial tissue, predictive algorithm reported as endometrial window of implantation (eg, pre-receptive, receptive, post-receptive)
Advanced Laboratory Testing (Laboratory Management)	0254U	Reproductive medicine (preimplantation genetic assessment), analysis of 24 chromosomes using embryonic DNA genomic sequence analysis for aneuploidy, and a mitochondrial DNA score in euploid embryos, results reported as normal (euploidy), monosomy, trisomy, or partial deletion/duplication, mosaicism, and segmental aneuploidy, per embryo tested
Advanced Laboratory Testing (Laboratory Management)	0258U	Autoimmune (psoriasis), mRNA, next-generation sequencing, gene expression profiling of 50-100 genes, skin-surface collection using adhesive patch, algorithm reported as likelihood of response to psoriasis biologics
Advanced Laboratory Testing (Laboratory Management)	0260U	Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insertions, translocations, and other structural variants by optical genome mapping
Advanced Laboratory Testing (Laboratory Management)	0262U	Oncology (solid tumor), gene expression profiling by real-time RT-PCR of 7 gene pathways (ER, AR, PI3K, MAPK, HH, TGFB, Notch), formalin-fixed paraffin-embedded (FFPE), algorithm reported as gene pathway activity score
Advanced Laboratory Testing (Laboratory Management)	0264U	Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insertions, translocations, and other structural variants by optical genome mapping
Advanced Laboratory Testing (Laboratory Management)	0265U	Rare constitutional and other heritable disorders, whole genome and mitochondrial DNA sequence analysis, blood, frozen and formalin-fixed paraffin-embedded (FFPE) tissue, saliva, buccal swabs or cell lines, identification of single nucleotide and copy number variants
Advanced Laboratory Testing (Laboratory Management)	0266U	Unexplained constitutional or other heritable disorders or syndromes, tissue-specific gene expression by whole-transcriptome and next-generation sequencing, blood, formalin-fixed paraffin-embedded (FFPE) tissue or fresh frozen tissue, reported as presence or absence of splicing or expression changes
Advanced Laboratory Testing (Laboratory Management)	0267U	Rare constitutional and other heritable disorders, identification of copy number variations, inversions, insertions, translocations, and other structural variants by optical genome mapping and whole genome sequencing
Advanced Laboratory Testing (Laboratory Management)	0268U	Hematology (atypical hemolytic uremic syndrome [aHUS]), genomic sequence analysis of 15 genes, blood, buccal swab, or amniotic fluid
Advanced Laboratory Testing (Laboratory Management)	0269U	Hematology (autosomal dominant congenital thrombocytopenia), genomic sequence analysis of 14 genes, blood, buccal swab, or amniotic fluid
Advanced Laboratory Testing (Laboratory Management)	0270U	Hematology (congenital coagulation disorders), genomic sequence analysis of 20 genes, blood, buccal swab, or amniotic fluid
Advanced Laboratory Testing (Laboratory Management)	0271U	Hematology (congenital neutropenia), genomic sequence analysis of 23 genes, blood, buccal swab, or amniotic fluid
Advanced Laboratory Testing (Laboratory Management)	0272U	Hematology (genetic bleeding disorders), genomic sequence analysis of 51 genes, blood, buccal swab, or amniotic fluid, comprehensive
Advanced Laboratory Testing (Laboratory Management)	0273U	Hematology (genetic hyperfibrinolysis, delayed bleeding), genomic sequence analysis of 8 genes (F13A1, F13B, FGA, FGB, FGG, SERPINA1, SERPINE1, SERPINF2, PLAU), blood, buccal swab, or amniotic fluid
Advanced Laboratory Testing (Laboratory Management)	0274U	Hematology (genetic platelet disorders), genomic sequence analysis of 43 genes, blood, buccal swab, or amniotic fluid
Advanced Laboratory Testing (Laboratory Management)	0276U	Hematology (inherited thrombocytopenia), genomic sequence analysis of 42 genes, blood, buccal swab, or amniotic fluid
Advanced Laboratory Testing (Laboratory Management)	0277U	Hematology (genetic platelet function disorder), genomic sequence analysis of 31 genes, blood, buccal swab, or amniotic fluid
Advanced Laboratory Testing (Laboratory Management)	0278U	Hematology (genetic thrombosis), genomic sequence analysis of 12 genes, blood, buccal swab, or amniotic fluid
Advanced Laboratory Testing (Laboratory Management)	0282U	Red blood cell antigen typing, DNA, genotyping of 12 blood group system genes to predict 44 red blood cell antigen phenotypes
Advanced Laboratory Testing (Laboratory Management)	0285U	Oncology, response to radiation, cell-free DNA, quantitative branched chain DNA amplification, plasma, reported as a radiation toxicity score
Advanced Laboratory Testing (Laboratory Management)	0286U	CEP72 (centrosomal protein, 72-KDa), NUDT15 (nudix hydrolase 15) and TPMT (thiopurine S-methyltransferase) (eg, drug metabolism) gene analysis, common variants
Advanced Laboratory Testing (Laboratory Management)	0287U	Oncology (thyroid), DNA and mRNA, next-generation sequencing analysis of 112 genes, fine needle aspirate or formalin-fixed paraffin-embedded (FFPE) tissue, algorithmic prediction of cancer recurrence, reported as a categorical risk result (low, intermediate, high)
Advanced Laboratory Testing (Laboratory Management)	0288U	Oncology (lung), mRNA, quantitative PCR analysis of 11 genes (BAG1, BRCA1, CDC6, CDK2AP1, ERBB3, FUT3, IL11, LCK, RND3, SH3BGR, WNT3A) and 3 reference genes (ESD, TBP, YAP1), formalin-fixed paraffin-embedded (FFPE) tumor tissue, algorithmic interpretation reported as a recurrence risk score

Advanced Laboratory Testing (Laboratory Management)	0289U	Neurology (Alzheimer disease), mRNA, gene expression profiling by RNA sequencing of 24 genes, whole blood, algorithm reported as predictive risk score
Advanced Laboratory Testing (Laboratory Management)	0290U	Pain management, mRNA, gene expression profiling by RNA sequencing of 36 genes, whole blood, algorithm reported as predictive risk score
Advanced Laboratory Testing (Laboratory Management)	0291U	Psychiatry (mood disorders), mRNA, gene expression profiling by RNA sequencing of 144 genes, whole blood, algorithm reported as predictive risk score
Advanced Laboratory Testing (Laboratory Management)	0292U	Psychiatry (stress disorders), mRNA, gene expression profiling by RNA sequencing of 72 genes, whole blood, algorithm reported as predictive risk score
Advanced Laboratory Testing (Laboratory Management)	0293U	Psychiatry (suicidal ideation), mRNA, gene expression profiling by RNA sequencing of 54 genes, whole blood, algorithm reported as predictive risk score
Advanced Laboratory Testing (Laboratory Management)	0294U	Longevity and mortality risk, mRNA, gene expression profiling by RNA sequencing of 18 genes, whole blood, algorithm reported as predictive risk score
Advanced Laboratory Testing (Laboratory Management)	0296U	Oncology (oral and/or oropharyngeal cancer), gene expression profiling by RNA sequencing at least 20 molecular features (eg, human and/or microbial mRNA), saliva, algorithm reported as positive or negative for signature associated with malignancy
Advanced Laboratory Testing (Laboratory Management)	0297U	Oncology (pan tumor), whole genome sequencing of paired malignant and normal DNA specimens, fresh or formalin-fixed paraffin-embedded (FFPE) tissue, blood or bone marrow, comparative sequence analyses and variant identification
Advanced Laboratory Testing (Laboratory Management)	0298U	Oncology (pan tumor), whole transcriptome sequencing of paired malignant and normal RNA specimens, fresh or formalin-fixed paraffin-embedded (FFPE) tissue, blood or bone marrow, comparative sequence analyses and expression level and chimeric transcript identification
Advanced Laboratory Testing (Laboratory Management)	0299U	Oncology (pan tumor), whole genome optical genome mapping of paired malignant and normal DNA specimens, fresh frozen tissue, blood, or bone marrow, comparative structural variant identification
Advanced Laboratory Testing (Laboratory Management)	0300U	Oncology (pan tumor), whole genome sequencing and optical genome mapping of paired malignant and normal DNA specimens, fresh tissue, blood, or bone marrow, comparative sequence analyses and variant identification
Advanced Laboratory Testing (Laboratory Management)	0306U	Oncology (minimal residual disease [MRD]), next-generation targeted sequencing analysis, cell-free DNA, initial (baseline) assessment to determine a patient-specific panel for future comparisons to evaluate for MRD
Advanced Laboratory Testing (Laboratory Management)	0307U	Oncology (minimal residual disease [MRD]), next-generation targeted sequencing analysis of a patient-specific panel, cell-free DNA, subsequent assessment with comparison to previously analyzed patient specimens to evaluate for MRD
Advanced Laboratory Testing (Laboratory Management)	0313U	Oncology (pancreas), DNA and mRNA next-generation sequencing analysis of 74 genes and analysis of CEA (CEACAM5) gene expression, pancreatic cyst fluid, algorithm reported as a categorical result (ie, negative, low probability of neoplasia or positive, high probability of neoplasia)
Advanced Laboratory Testing (Laboratory Management)	0314U	Oncology (cutaneous melanoma), mRNA gene expression profiling by RT-PCR of 35 genes (32 content and 3 housekeeping), utilizing formalin-fixed paraffin-embedded (FFPE) tissue, algorithm reported as a categorical result (ie, benign, intermediate, malignant)
Advanced Laboratory Testing (Laboratory Management)	0315U	Oncology (cutaneous squamous cell carcinoma), mRNA gene expression profiling by RT-PCR of 40 genes (34 content and 6 housekeeping), utilizing formalin-fixed paraffin-embedded (FFPE) tissue, algorithm reported as a categorical risk result (ie, Class 1, Class 2A, Class 2B)
Advanced Laboratory Testing (Laboratory Management)	0317U	Oncology (lung cancer), four-probe FISH (3q29, 3p22.1, 10q22.3, 10cen) assay, whole blood, predictive algorithm generated evaluation reported as decreased or increased risk for lung cancer
Advanced Laboratory Testing (Laboratory Management)	0318U	Pediatrics (congenital epigenetic disorders), whole genome methylation analysis by microarray for 50 or more genes, blood
Advanced Laboratory Testing (Laboratory Management)	0319U	Nephrology (renal transplant), RNA expression by select transcriptome sequencing, using pretransplant peripheral
Advanced Laboratory Testing (Laboratory Management)	0320U	Nephrology (renal transplant), RNA expression by select transcriptome sequencing, using posttransplant peripheral blood, algorithm reported as a risk score for acute cellular rejection
Advanced Laboratory Testing (Laboratory Management)	0326U	Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free circulating DNA analysis of 83 or more genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability and tumor mutational burden
Advanced Laboratory Testing (Laboratory Management)	0329U	Oncology (neoplasia), exome and transcriptome sequence analysis for sequence variants, gene copy number amplifications and deletions, gene rearrangements, microsatellite instability and tumor mutational burden utilizing DNA and RNA from tumor with DNA from normal blood or saliva for subtraction, report of clinically significant mutation(s) with therapy associations
Advanced Laboratory Testing (Laboratory Management)	0331U	Oncology (hematolymphoid neoplasia), optical genome mapping for copy number alterations and gene rearrangements utilizing DNA from blood or bone marrow, report of clinically significant alternations
Advanced Laboratory Testing (Laboratory Management)	0332U	Oncology (pan-tumor), genetic profiling of 8 DNA-regulatory (epigenetic) markers by quantitative polymerase chain reaction (qPCR), whole blood, reported as a high or low probability of responding to immune checkpoint–inhibitor therapy
Advanced Laboratory Testing (Laboratory Management)	0333U	Oncology (liver), surveillance for hepatocellular carcinoma (HCC) in high-risk patients, analysis of methylation patterns on circulating cell-free DNA (cfDNA) plus measurement of serum of AFP/AFP-L3 and oncoprotein des-gamma-carboxy prothrombin (DCP), algorithm reported as normal or abnormal result
Advanced Laboratory Testing (Laboratory Management)	0334U	Oncology (solid organ), targeted genomic sequence analysis, formalin-fixed paraffin-embedded (FFPE) tumor tissue, DNA analysis, 84 or more genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability and tumor mutational burden
Advanced Laboratory Testing (Laboratory Management)	0335U	Rare diseases (constitutional/heritable disorders), whole genome sequence analysis, including small sequence changes, copy number variants, deletions, duplications, mobile element insertions, uniparental disomy (UPD), inversions, aneuploidy, mitochondrial genome sequence analysis with heteroplasmy and large deletions, short tandem repeat (STR) gene expansions, fetal sample, identification and categorization of genetic variants
Advanced Laboratory Testing (Laboratory Management)	0336U	Rare diseases (constitutional/heritable disorders), whole genome sequence analysis, including small sequence changes, copy number variants, deletions, duplications, mobile element insertions, uniparental disomy (UPD), inversions, aneuploidy, mitochondrial genome sequence analysis with heteroplasmy and large deletions, short tandem repeat (STR) gene expansions, blood or saliva, identification and categorization of genetic variants, each comparator genome (eg, parent)

Advanced Laboratory Testing (Laboratory Management)	0339U	Oncology (prostate), mRNA expression profiling of HOXC6 and DLX1, reverse transcription polymerase chain reaction (RT-PCR), first-void urine following digital rectal examination, algorithm reported as probability of high-grade cancer
Advanced Laboratory Testing (Laboratory Management)	0340U	Oncology (pan-cancer), analysis of minimal residual disease (MRD) from plasma, with assays personalized to each patient based on prior next-generation sequencing of the patient's tumor and germline DNA, reported as absence or presence of MRD, with disease-burden correlation, if appropriate
Advanced Laboratory Testing (Laboratory Management)	0341U	Fetal aneuploidy DNA sequencing comparative analysis, fetal DNA from products of conception, reported as normal (euploidy), monosomy, trisomy, or partial deletion/duplication, mosaicism, and segmental aneuploid
Advanced Laboratory Testing (Laboratory Management)	0343U	Oncology (prostate), exosome-based analysis of 442 small noncoding RNAs (sncRNAs) by quantitative reverse transcription polymerase chain reaction (RT-qPCR), urine, reported as molecular evidence of no-, low-, intermediate- or high-risk of prostate cancer
Advanced Laboratory Testing (Laboratory Management)	0345U	Psychiatry (eg, depression, anxiety, attention deficit hyperactivity disorder [ADHD]), genomic analysis panel, variant analysis of 15 genes, including deletion/duplication analysis of CYP2D6
Advanced Laboratory Testing (Laboratory Management)	0347U	Drug metabolism or processing (multiple conditions), whole blood or buccal specimen, DNA analysis, 16 gene report, with variant analysis and reported phenotypes
Advanced Laboratory Testing (Laboratory Management)	0348U	Drug metabolism or processing (multiple conditions), whole blood or buccal specimen, DNA analysis, 25 gene report, with variant analysis and reported phenotypes
Advanced Laboratory Testing (Laboratory Management)	0349U	Drug metabolism or processing (multiple conditions), whole blood or buccal specimen, DNA analysis, 27 gene report, with variant analysis including reported phenotypes and impacted gene-drug interactions
Advanced Laboratory Testing (Laboratory Management)	0350U	Drug metabolism or processing (multiple conditions), whole blood or buccal specimen, DNA analysis, 27 gene report, with variant analysis and reported phenotypes
Advanced Laboratory Testing (Laboratory Management)	G0327	Colorectal cancer screening; blood-based biomarker
Advanced Laboratory Testing (Laboratory Management)	G9143	Warfarin responsiveness testing by genetic technique using any method, any number of specimen(s)
Advanced Laboratory Testing (Laboratory Management)	S3800	Genetic testing for amyotrophic lateral sclerosis (als)
Advanced Laboratory Testing (Laboratory Management)	S3840	Dna analysis for germline mutations of the ret proto-oncogene for susceptibility to multiple endocrine neoplasia type 2
Advanced Laboratory Testing (Laboratory Management)	S3841	Genetic testing for retinoblastoma
Advanced Laboratory Testing (Laboratory Management)	S3842	Genetic testing for von hippel-lindau disease
Advanced Laboratory Testing (Laboratory Management)	S3844	Dna analysis of the connexin 26 gene (gjb2) for susceptibility to congenital, profound deafness
Advanced Laboratory Testing (Laboratory Management)	S3845	Genetic testing for alpha-thalassemia
Advanced Laboratory Testing (Laboratory Management)	S3846	Genetic testing for hemoglobin e beta-thalassemia
Advanced Laboratory Testing (Laboratory Management)	S3850	Genetic testing for sickle cell anemia
Advanced Laboratory Testing (Laboratory Management)	S3852	Dna analysis for apoe epsilon 4 allele for susceptibility to alzheimer's disease
Advanced Laboratory Testing (Laboratory Management)	S3854	Gene expression profiling panel for use in the management of breast cancer treatment
Advanced Laboratory Testing (Laboratory Management)	S3861	Genetic testing, sodium channel, voltage-gated, type v, alpha subunit (scn5a) and variants for suspected brugada syndrome
Advanced Laboratory Testing (Laboratory Management)	S3865	Comprehensive gene sequence analysis for hypertrophic cardiomyopathy
Advanced Laboratory Testing (Laboratory Management)	S3866	Genetic analysis for a specific gene mutation for hypertrophic cardiomyopathy (hcm) in an individual with a known hcm mutation in the family
Advanced Laboratory Testing (Laboratory Management)	S3870	Comparative genomic hybridization (cgh) microarray testing for developmental delay, autism spectrum disorder and/or intellectual disability
Ambulance	A0426	AMBULANCE SERVICE, ADVANCED LIFE SUPPORT, NON-EMERGENCY TRANSPORT, LEVEL 1 (ALS1)
Ambulance	A0430	AMBULANCE SERVICE, CONVENTIONAL AIR SERVICES, TRANSPORT, ONE WAY (FIXED WING)
Ambulance	A0431	AMBULANCE SERVICE, CONVENTIONAL AIR SERVICES, TRANSPORT, ONE WAY (ROTARY WING)
Ambulance	A0432	PARAMEDIC INTERCEPT (PI), RURAL AREA, TRANSPORT FURNISHED BY A VOLUNTEER AMBULANCE COMPANY WHICH IS PROHIBITED BY STATE LAW FROM BILLING THIRD PARTY PAYERS
Ambulance	A0999	UNLISTED AMBULANCE SERVICE
Durable Medical Equipment	E0187	WATER PRESSURE MATTRESS
Durable Medical Equipment	E0193	POWERED AIR FLOTATION BED (LOW AIR LOSS THERAPY)
Durable Medical Equipment	E0197	AIR PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH
Durable Medical Equipment	E0198	WATER PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH
Durable Medical Equipment	E0295	HOSPITAL BED, SEMI-ELECTRIC (HEAD AND FOOT ADJUSTMENT), WITHOUT SIDE RAILS, WITHOUT MATTRESS
Durable Medical Equipment	E0296	HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS), WITHOUT SIDE RAILS, WITH MATTRESS
Durable Medical Equipment	E0297	HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS), WITHOUT SIDE RAILS, WITHOUT MATTRESS
Durable Medical Equipment	E0302	HOSPITAL BED, EXTRA HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 600 POUNDS, WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS
Durable Medical Equipment	E0304	HOSPITAL BED, EXTRA HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 600 POUNDS, WITH ANY TYPE SIDE RAILS, WITH MATTRESS
Durable Medical Equipment	E0316	SAFETY ENCLOSURE FRAME/CANOPY FOR USE WITH HOSPITAL BED, ANY TYPE

Durable Medical Equipment	E0372	POWERED AIR OVERLAY FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH
Durable Medical Equipment	E0425	STATIONARY COMPRESSED GAS SYSTEM, PURCHASE; INCLUDES REGULATOR, FLOWMETER, HUMIDIFIER, NEBULIZER, CANNULA OR MASK, AND TUBING
Durable Medical Equipment	E0440	STATIONARY LIQUID OXYGEN SYSTEM, PURCHASE; INCLUDES USE OF RESERVOIR, CONTENTS INDICATOR, REGULATOR, FLOWMETER, HUMIDIFIER, NEBULIZER, CANNULA OR MASK, AND TUBING
Durable Medical Equipment	E0483	HIGH FREQUENCY CHEST WALL OSCILLATION AIR-PULSE GENERATOR SYSTEM, (INCLUDES HOSES AND VEST), EACH
Durable Medical Equipment	0424T	INSERTION OR REPLACEMENT OF NEUROSTIMULATOR SYSTEM FOR TREATMENT OF CENTRAL SLEEP APNEA; COMPLETE SYSTEM (TRANSVENOUS PLACEMENT OF RIGHT OR LEFT STIMULATION LEAD, SENSING LEAD, IMPLANTABLE PULSE GENERATOR)
Durable Medical Equipment	E0486	ORAL DEVICE/APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT
Durable Medical Equipment	E0635	PATIENT LIFT, ELECTRIC WITH SEAT OR SLING
Durable Medical Equipment	E0636	MULTIPOSITIONAL PATIENT SUPPORT SYSTEM, WITH INTEGRATED LIFT, PATIENT ACCESSIBLE CONTROLS
Durable Medical Equipment	E0637	COMBINATION SIT TO STAND FRAME/TABLE SYSTEM, ANY SIZE INCLUDING PEDIATRIC, WITH SEAT LIFT FEATURE, WITH OR WITHOUT WHEELS
Durable Medical Equipment	E0638	STANDING FRAME/TABLE SYSTEM, ONE POSITION (E.G., UPRIGHT, SUPINE OR PRONE STANDER), ANY SIZE INCLUDING PEDIATRIC, WITH OR WITHOUT WHEELS
Durable Medical Equipment	E0639	PATIENT LIFT, MOVEABLE FROM ROOM TO ROOM WITH DISASSEMBLY AND REASSEMBLY, INCLUDES ALL COMPONENTS/ACCESSORIES
Durable Medical Equipment	E0642	STANDING FRAME/TABLE SYSTEM, MOBILE (DYNAMIC STANDER), ANY SIZE INCLUDING PEDIATRIC
Durable Medical Equipment	E1035	MULTI-POSITIONAL PATIENT TRANSFER SYSTEM, WITH INTEGRATED SEAT, OPERATED BY CARE GIVER, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 LBS
Durable Medical Equipment	E1036	MULTI-POSITIONAL PATIENT TRANSFER SYSTEM, EXTRA-WIDE, WITH INTEGRATED SEAT, OPERATED BY CAREGIVER, PATIENT WEIGHT CAPACITY GREATER THAN 300 LBS
Durable Medical Equipment	E0691	ULTRAVIOLET LIGHT THERAPY SYSTEM, INCLUDES BULBS/LAMPS, TIMER AND EYE PROTECTION; TREATMENT AREA 2 SQUARE FEET OR LESS
Durable Medical Equipment	E0692	ULTRAVIOLET LIGHT THERAPY SYSTEM PANEL, INCLUDES BULBS/LAMPS, TIMER AND EYE PROTECTION, 4 FOOT PANEL
Durable Medical Equipment	E0693	ULTRAVIOLET LIGHT THERAPY SYSTEM PANEL, INCLUDES BULBS/LAMPS, TIMER AND EYE PROTECTION; 6 FOOT PANEL
Durable Medical Equipment	E0694	ULTRAVIOLET MULTIDIRECTIONAL LIGHT THERAPY SYSTEM IN 6 FOOT CABINET, INCLUDES BULBS/LAMPS, TIMER AND EYE PROTECTION
Durable Medical Equipment	E0747	OSTEOGENESIS STIMULATOR, ELECTRICAL, NON-INVASIVE, OTHER THAN SPINAL APPLICATIONS
Durable Medical Equipment	E0760	OSTEOGENESIS STIMULATOR, LOW INTENSITY ULTRASOUND, NON-INVASIVE
Durable Medical Equipment	E0764	FUNCTIONAL NEUROMUSCULAR STIMULATION, TRANSCUTANEOUS STIMULATION OF SEQUENTIAL MUSCLE GROUPS OF AMBULATION WITH COMPUTER CONTROL, USED FOR WALKING BY SPINAL CORD INJURED, ENTIRE SYSTEM, AFTER COMPLETION OF TRAINING PROGRAM
Durable Medical Equipment	E0766	ELECTRICAL STIMULATION DEVICE USED FOR CANCER TREATMENT, INCLUDES ALL ACCESSORIES, ANY TYPE
Durable Medical Equipment	E2510	SPEECH GENERATING DEVICE, SYNTHESIZED SPEECH, PERMITTING MULTIPLE METHODS OF MESSAGE FORMULATION AND MULTIPLE METHODS OF DEVICE ACCESS
Durable Medical Equipment	E2511	SPEECH GENERATING SOFTWARE PROGRAM, FOR PERSONAL COMPUTER OR PERSONAL DIGITAL ASSISTANT
Durable Medical Equipment	E2512	ACCESSORY FOR SPEECH GENERATING DEVICE, MOUNTING SYSTEM
Durable Medical Equipment	E2599	ACCESSORY FOR SPEECH GENERATING DEVICE, NOT OTHERWISE CLASSIFIED
Durable Medical Equipment	E1011	MODIFICATION TO PEDIATRIC SIZE WHEELCHAIR, WIDTH ADJUSTMENT PACKAGE (NOT TO BE DISPENSED WITH INITIAL CHAIR)
Durable Medical Equipment	E1017	HEAVY DUTY SHOCK ABSORBER FOR HEAVY DUTY OR EXTRA HEAVY DUTY MANUAL WHEELCHAIR, EACH
Durable Medical Equipment	E1018	HEAVY DUTY SHOCK ABSORBER FOR HEAVY DUTY OR EXTRA HEAVY DUTY POWER WHEELCHAIR, EACH
Durable Medical Equipment	E1037	TRANSPORT CHAIR, PEDIATRIC SIZE
Durable Medical Equipment	E1060	FULLY-RECLINING WHEELCHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH) ELEVATING LEGREST, SWING AWAY DETACHABLE
Durable Medical Equipment	E1083	HEMI-WHEELCHAIR; FIXED FULL LENGTH ARMS, SWING AWAY, DETACHABLE ELEVATING LEG REST
Durable Medical Equipment	E1100	SEMI-RECLINING WHEELCHAIR; FIXED FULL LENGTH ARMS, SWING AWAY, DETACHABLE, ELEVATING LEGRESTS
Durable Medical Equipment	E1220	WHEELCHAIR; SPECIALLY SIZED OR CONSTRUCTED. (INDICATE BRAND NAME, MODEL NUMBER, IF ANY) AND JUSTIFICATION
Durable Medical Equipment	E1227	SPECIAL HEIGHT ARMS FOR WHEELCHAIR
Durable Medical Equipment	E1228	SPECIAL BACK HEIGHT FOR WHEELCHAIR
Durable Medical Equipment	E1231	WHEELCHAIR, PEDIATRIC SIZE, TILT-IN-SPACE, RIGID, ADJUSTABLE, WITH SEATING SYSTEM
Durable Medical Equipment	E1232	WHEELCHAIR, PEDIATRIC SIZE, TILT-IN-SPACE, FOLDING, ADJUSTABLE, WITH SEATING SYSTEM
Durable Medical Equipment	E1233	WHEELCHAIR, PEDIATRIC SIZE, TILT-IN-SPACE, RIGID, ADJUSTABLE, WITHOUT SEATING SYSTEM
Durable Medical Equipment	E1234	WHEELCHAIR, PEDIATRIC SIZE, TILT-IN-SPACE, FOLDING, ADJUSTABLE, WITHOUT SEATING SYSTEM
Durable Medical Equipment	E1235	WHEELCHAIR, PEDIATRIC SIZE, RIGID, ADJUSTABLE, WITH SEATING SYSTEM
Durable Medical Equipment	E1237	WHEELCHAIR, PEDIATRIC SIZE, RIGID, ADJUSTABLE, WITHOUT SEATING SYSTEM
Durable Medical Equipment	E1238	WHEELCHAIR, PEDIATRIC SIZE, FOLDING, ADJUSTABLE, WITHOUT SEATING SYSTEM
Durable Medical Equipment	E1239	POWER WHEELCHAIR, PEDIATRIC SIZE, NOT OTHERWISE SPECIFIED

Durable Medical Equipment	E1295	HEAVY DUTY WHEELCHAIR; FIXED FULL LENGTH ARMS, ELEVATING LEGREST
Durable Medical Equipment	E2227	MANUAL WHEELCHAIR ACCESSORY, GEAR REDUCTION DRIVE WHEEL, EACH
Durable Medical Equipment	E2230	MANUAL WHEELCHAIR ACCESSORY, MANUAL STANDING SYSTEM
Durable Medical Equipment	E2295	MANUAL WHEELCHAIR ACCESSORY, FOR PEDIATRIC SIZE WHEELCHAIR, DYNAMIC SEATING FRAME, ALLOWS COORDINATION MOVEMENT OF MULTIPLE POSITIONING FEATURES
Durable Medical Equipment	E2628	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, RECLINING
Durable Medical Equipment	E2630	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT, MONOSUSPENSION ARM AND HAND SUPPORT, OVERHEAD ELBOW FOREARM HAND SLING SUPPORT, YOKE TYPE SUSPENSION SUPPORT
Durable Medical Equipment	E2632	WHEELCHAIR ACCESSORY, ADDITION TO MOBILE ARM SUPPORT, OFFSET OR LATERAL ROCKER ARM WITH ELASTIC BALANCE CONTROL
Durable Medical Equipment	E2633	WHEELCHAIR ACCESSORY, ADDITION TO MOBILE ARM SUPPORT, SUPINATOR
Durable Medical Equipment	K0005	ULTRALIGHTWEIGHT WHEELCHAIR
Durable Medical Equipment	K0050	RATCHET ASSEMBLY
Durable Medical Equipment	E1230	POWER OPERATED VEHICLE (THREE OR FOUR WHEEL NONHIGHWAY) SPECIFY BRAND NAME AND MODEL NUMBER
Durable Medical Equipment	E0984	MANUAL WHEELCHAIR ACCESSORY, POWER ADD-ON TO CONVERT MANUAL WHEELCHAIR TO MOTORIZED WHEELCHAIR, TILLER CONTROL
Durable Medical Equipment	E1002	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, TILT ONLY
Durable Medical Equipment	E1004	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, RECLINE ONLY, WITH MECHANICAL SHEAR REDUCTION
Durable Medical Equipment	E1005	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, RECLINE ONLY, WITH POWER SHEAR REDUCTION
Durable Medical Equipment	E1006	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, COMBINATION TILT AND RECLINE, WITHOUT SHEAR REDUCTION
Durable Medical Equipment	E1007	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, COMBINATION TILT AND RECLINE, WITH MECHANICAL SHEAR REDUCTION
Durable Medical Equipment	E1008	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, COMBINATION TILT AND RECLINE, WITH POWER SHEAR REDUCTION
Durable Medical Equipment	E1009	WHEELCHAIR ACCESSORY, ADDITION TO POWER SEATING SYSTEM, MECHANICALLY LINKED LEG ELEVATION SYSTEM, INCLUDING PUSHROD AND LEG REST, EACH
Durable Medical Equipment	E1010	WHEELCHAIR ACCESSORY, ADDITION TO POWER SEATING SYSTEM, POWER LEG ELEVATION SYSTEM, INCLUDING LEGREST, PAIR
Durable Medical Equipment	E2300	WHEELCHAIR ACCESSORY, POWER SEAT ELEVATION SYSTEM, ANY TYPE
Durable Medical Equipment	E2301	WHEELCHAIR ACCESSORY, POWER STANDING SYSTEM, ANY TYPE
Durable Medical Equipment	E2324	POWER WHEELCHAIR ACCESSORY, CHIN CUP FOR CHIN CONTROL INTERFACE
Durable Medical Equipment	E2327	POWER WHEELCHAIR ACCESSORY, HEAD CONTROL INTERFACE, MECHANICAL, PROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS, MECHANICAL DIRECTION CHANGE SWITCH, AND FIXED MOUNTING HARDWARE
Durable Medical Equipment	E2329	POWER WHEELCHAIR ACCESSORY, HEAD CONTROL INTERFACE, CONTACT SWITCH MECHANISM, NONPROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS, MECHANICAL STOP SWITCH, MECHANICAL DIRECTION CHANGE SWITCH, HEAD ARRAY, AND FIXED MOUNTING HARDWARE
Durable Medical Equipment	E2341	POWER WHEELCHAIR ACCESSORY, NONSTANDARD SEAT FRAME WIDTH, 24-27 INCHES
Durable Medical Equipment	E2343	POWER WHEELCHAIR ACCESSORY, NONSTANDARD SEAT FRAME DEPTH, 22-25 INCHES
Durable Medical Equipment	E2358	POWER WHEELCHAIR ACCESSORY, GROUP 34 NON-SEALED LEAD ACID BATTERY, EACH ,
Durable Medical Equipment	E2362	POWER WHEELCHAIR ACCESSORY, GROUP 24 NON-SEALED LEAD ACID BATTERY, EACH
Durable Medical Equipment	K0010	STANDARD - WEIGHT FRAME MOTORIZED/POWER WHEELCHAIR
Durable Medical Equipment	K0011	STANDARD - WEIGHT FRAME MOTORIZED/POWER WHEELCHAIR WITH PROGRAMMABLE CONTROL PARAMETERS FOR SPEED ADJUSTMENT, TREMOR DAMPENING, ACCELERATION CONTROL AND BRAKING
Durable Medical Equipment	K0012	LIGHTWEIGHT PORTABLE MOTORIZED/POWER WHEELCHAIR
Durable Medical Equipment	K0014	OTHER MOTORIZED/POWER WHEELCHAIR BASE
Durable Medical Equipment	K0098	DRIVE BELT FOR POWER WHEELCHAIR
Durable Medical Equipment	K0800	POWER OPERATED VEHICLE, GROUP 1 STANDARD, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0801	POWER OPERATED VEHICLE, GROUP 1 HEAVY DUTY, PATIENT WEIGHT CAPACITY, 301 TO 450 POUNDS
Durable Medical Equipment	K0802	POWER OPERATED VEHICLE, GROUP 1 VERY HEAVY DUTY, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
Durable Medical Equipment	K0806	POWER OPERATED VEHICLE, GROUP 2 STANDARD, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0807	POWER OPERATED VEHICLE, GROUP 2 HEAVY DUTY, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
Durable Medical Equipment	K0808	POWER OPERATED VEHICLE, GROUP 2 VERY HEAVY DUTY, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
Durable Medical Equipment	K0812	POWER OPERATED VEHICLE, NOT OTHERWISE CLASSIFIED
Durable Medical Equipment	K0813	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0814	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0815	POWER WHEELCHAIR, GROUP 1 STANDARD, SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0816	POWER WHEELCHAIR, GROUP 1 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0820	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0821	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS

Durable Medical Equipment	K0822	POWER WHEELCHAIR, GROUP 2 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0823	POWER WHEELCHAIR, GROUP 2 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0824	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
Durable Medical Equipment	K0825	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
Durable Medical Equipment	K0826	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
Durable Medical Equipment	K0827	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
Durable Medical Equipment	K0828	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE
Durable Medical Equipment	K0829	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE
Durable Medical Equipment	K0830	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0831	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0835	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0836	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0837	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
Durable Medical Equipment	K0838	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
Durable Medical Equipment	K0839	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
Durable Medical Equipment	K0840	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE
Durable Medical Equipment	K0841	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0842	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0843	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
Durable Medical Equipment	K0848	POWER WHEELCHAIR, GROUP 3 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0849	POWER WHEELCHAIR, GROUP 3 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0850	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
Durable Medical Equipment	K0851	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
Durable Medical Equipment	K0852	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
Durable Medical Equipment	K0853	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY, 451 TO 600 POUNDS
Durable Medical Equipment	K0854	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE
Durable Medical Equipment	K0855	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE
Durable Medical Equipment	K0856	POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0857	POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0858	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
Durable Medical Equipment	K0859	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
Durable Medical Equipment	K0860	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
Durable Medical Equipment	K0861	POWER WHEELCHAIR, GROUP 3 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0862	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
Durable Medical Equipment	K0863	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
Durable Medical Equipment	K0864	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE
Durable Medical Equipment	K0868	POWER WHEELCHAIR, GROUP 4 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0869	POWER WHEELCHAIR, GROUP 4 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0870	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
Durable Medical Equipment	K0871	POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS

Durable Medical Equipment	K0877	POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0878	POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0879	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
Durable Medical Equipment	K0880	POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT 451 TO 600 POUNDS
Durable Medical Equipment	K0884	POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0885	POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0886	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
Durable Medical Equipment	K0890	POWER WHEELCHAIR, GROUP 5 PEDIATRIC, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS
Durable Medical Equipment	K0891	POWER WHEELCHAIR, GROUP 5 PEDIATRIC, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS
Durable Medical Equipment	K0898	POWER WHEELCHAIR, NOT OTHERWISE CLASSIFIED
Durable Medical Equipment	K0899	POWER MOBILITY DEVICE, NOT CODED BY DME PDAC OR DOES NOT MEET CRITERIA
Durable Medical Equipment	E1310	WHIRLPOOL, NON-PORTABLE (BUILT-IN TYPE)
Durable Medical Equipment	K0606	AUTOMATIC EXTERNAL DEFIBRILLATOR, WITH INTEGRATED ELECTROCARDIOGRAM
Home Health	S5108	HOME CARE TRAINING TO HOME CARE CLIENT, PER 15 MINUTES
Home Health	S5109	HOME CARE TRAINING TO HOME CARE CLIENT, PER SESSION
Home Health	S5110	HOME CARE TRAINING, FAMILY; PER 15 MINUTES
Home Health	S5111	HOME CARE TRAINING, FAMILY; PER SESSION
Home Health	S5115	HOME CARE TRAINING, NON-FAMILY; PER 15 MINUTES
Home Health	S5116	HOME CARE TRAINING, NON-FAMILY; PER SESSION
Home Health	S5181	HOME HEALTH RESPIRATORY THERAPY, NOS, PER DIEM
Home Health	S9123	NURSING CARE, IN THE HOME; BY REGISTERED NURSE, PER HOUR (USE FOR GENERAL NURSING CARE ONLY, NOT TO BE USED WHEN CPT CODES 99500-99602 CAN BE USED)
Home Health	S9124	NURSING CARE, IN THE HOME; BY LICENSED PRACTICAL NURSE, PER HOUR
Hospital Outpatient	99183	PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL ATTENDANCE AND SUPERVISION OF HYPERBARIC OXYGEN THERAPY, PER SESSION
Hospital Outpatient	G0277	HYPERBARIC OXYGEN UNDER PRESSURE, FULL BODY CHAMBER, PER 30 MINUTE INTERVAL
Inpatient Detoxification/Rehabilitation	H0008	ALCOHOL AND/OR DRUG SERVICES; SUB-ACUTE DETOXIFICATION (HOSPITAL INPATIENT)
Inpatient Detoxification/Rehabilitation	H0009	ALCOHOL AND/OR DRUG SERVICES; ACUTE DETOXIFICATION (HOSPITAL INPATIENT)
Inpatient Detoxification/Rehabilitation	H0010	ALCOHOL AND/OR DRUG SERVICES; SUB-ACUTE DETOXIFICATION (RESIDENTIAL ADDICTION PROGRAM INPATIENT)
Inpatient Detoxification/Rehabilitation	H0011	ALCOHOL AND/OR DRUG SERVICES; ACUTE DETOXIFICATION (RESIDENTIAL ADDICTION PROGRAM INPATIENT)
Interventional Pain Management (Musculoskeletal)	62281	Injection/infusion of neurolytic substance (e.g., alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, cervical or thoracic
Interventional Pain Management (Musculoskeletal)	62282	Injection/infusion of neurolytic substance (e.g., alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, lumbar, sacral (caudal)
Interventional Pain Management (Musculoskeletal)	62320	Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance
Interventional Pain Management (Musculoskeletal)	62321	Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (i.e., fluoroscopy or CT)
Interventional Pain Management (Musculoskeletal)	62322	Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance
Interventional Pain Management (Musculoskeletal)	62323	Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (i.e., fluoroscopy or CT)
Interventional Pain Management (Musculoskeletal)	62324	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance
Interventional Pain Management (Musculoskeletal)	62325	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (i.e., fluoroscopy or CT)
Interventional Pain Management (Musculoskeletal)	62326	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance
Interventional Pain Management (Musculoskeletal)	62327	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (i.e., fluoroscopy or CT)
Interventional Pain Management (Musculoskeletal)	64479	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, single level
Interventional Pain Management (Musculoskeletal)	64480	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, each additional level (List separately in addition to code for primary procedure)

Interventional Pain Management (Musculoskeletal)	64483	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level
Interventional Pain Management (Musculoskeletal)	64484	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)
Interventional Pain Management (Musculoskeletal)	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
Interventional Pain Management (Musculoskeletal)	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)
Interventional Pain Management (Musculoskeletal)	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)
Interventional Pain Management (Musculoskeletal)	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
Interventional Pain Management (Musculoskeletal)	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)
Interventional Pain Management (Musculoskeletal)	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)
Interventional Pain Management (Musculoskeletal)	64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint
Interventional Pain Management (Musculoskeletal)	64634	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure)
Interventional Pain Management (Musculoskeletal)	64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint
Interventional Pain Management (Musculoskeletal)	64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)
Interventional Pain Management (Musculoskeletal)	62350	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy
Interventional Pain Management (Musculoskeletal)	62351	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; with laminectomy
Interventional Pain Management (Musculoskeletal)	62360	Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir
Interventional Pain Management (Musculoskeletal)	62361	Implantation or replacement of device for intrathecal or epidural drug infusion; nonprogrammable pump
Interventional Pain Management (Musculoskeletal)	62362	Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming
Interventional Pain Management (Musculoskeletal)	0627T	Percutaneous injection of allogeneic cellular and/or tissue- based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; first level
Interventional Pain Management (Musculoskeletal)	0628T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; each additional level (List separately in addition to code for primary procedure)
Interventional Pain Management (Musculoskeletal)	0629T	Percutaneous injection of allogeneic cellular and/or tissue- based product, intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; first level
Interventional Pain Management (Musculoskeletal)	0630T	Percutaneous injection of allogeneic cellular and/or tissue- based product, intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; each additional level (List separately in addition to code for primary procedure)
Interventional Pain Management (Musculoskeletal)	64510	Injection, anesthetic agent; stellate ganglion (cervical sympathetic)
Interventional Pain Management (Musculoskeletal)	64520	Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic)
Interventional Pain Management (Musculoskeletal)	22526	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level
Interventional Pain Management (Musculoskeletal)	22527	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; 1 or more additional levels (List separately in addition to code for primary procedure)
Interventional Pain Management (Musculoskeletal)	62263	Percutaneous lysis of epidural adhesions using solution injection (e.g., hypertonic saline, enzyme) or mechanical means (e.g., catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days
Interventional Pain Management (Musculoskeletal)	62264	Percutaneous lysis of epidural adhesions using solution injection (e.g., hypertonic saline, enzyme) or mechanical means (e.g., catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day
Interventional Pain Management (Musculoskeletal)	62280	Injection/infusion of neurolytic substance (e.g., alcohol, phenol, iced saline solutions), with or without other therapeutic substance; subarachnoid
Interventional Pain Management (Musculoskeletal)	62292	Injection procedure for chemonucleolysis, including discography, intervertebral disc, single or multiple levels, lumbar
Interventional Pain Management (Musculoskeletal)	64451	Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)
Interventional Pain Management (Musculoskeletal)	64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)
Interventional Pain Management (Musculoskeletal)	G0260	Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography
Interventional Pain Management (Musculoskeletal)	63650	Percutaneous implantation of neurostimulator electrode array, epidural
Interventional Pain Management (Musculoskeletal)	63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural

Interventional Pain Management (Musculoskeletal)	63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
Interventional Pain Management (Musculoskeletal)	27096	Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed
Joint Services (Musculoskeletal)	29916	Arthroscopy, hip, surgical; with labral repair
Joint Services (Musculoskeletal)	29915	Arthroscopy, hip, surgical; with acetabuloplasty (i.e., treatment of pincer lesion)
Joint Services (Musculoskeletal)	29914	Arthroscopy, hip, surgical; with femoroplasty (i.e., treatment of cam lesion)
Joint Services (Musculoskeletal)	29863	Arthroscopy, hip, surgical; with synovectomy
Joint Services (Musculoskeletal)	29862	Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum
Joint Services (Musculoskeletal)	29861	Arthroscopy, hip, surgical; with removal of loose body or foreign body
Joint Services (Musculoskeletal)	29860	Arthroscopy, hip, diagnostic with or without synovial biopsy (separate procedure)
Joint Services (Musculoskeletal)	27138	Revision of total hip arthroplasty; femoral component only, with or without allograft
Joint Services (Musculoskeletal)	27137	Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft
Joint Services (Musculoskeletal)	27134	Revision of total hip arthroplasty; both components, with or without autograft or allograft
Joint Services (Musculoskeletal)	27132	Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft
Joint Services (Musculoskeletal)	27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft
Joint Services (Musculoskeletal)	27125	Hemiarthroplasty, hip, partial (e.g., femoral stem prosthesis, bipolar arthroplasty)
Joint Services (Musculoskeletal)	29889	Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction
Joint Services (Musculoskeletal)	29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
Joint Services (Musculoskeletal)	29887	Arthroscopy, knee, surgical; drilling for intact osteochondritis dissecans lesion with internal fixation
Joint Services (Musculoskeletal)	29886	Arthroscopy, knee, surgical; drilling for intact osteochondritis dissecans lesion
Joint Services (Musculoskeletal)	29885	Arthroscopy, knee, surgical; drilling for osteochondritis dissecans with bone grafting, with or without internal fixation (including debridement of base of lesion)
Joint Services (Musculoskeletal)	29884	Arthroscopy, knee, surgical; with lysis of adhesions, with or without manipulation (separate procedure)
Joint Services (Musculoskeletal)	29883	Arthroscopy, knee, surgical; with meniscus repair (medial AND lateral)
Joint Services (Musculoskeletal)	29882	Arthroscopy, knee, surgical; with meniscus repair (medial OR lateral)
Joint Services (Musculoskeletal)	29881	Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed
Joint Services (Musculoskeletal)	29880	Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed
Joint Services (Musculoskeletal)	29879	Arthroscopy, knee, surgical; abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture
Joint Services (Musculoskeletal)	29877	Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)
Joint Services (Musculoskeletal)	29876	Arthroscopy, knee, surgical; synovectomy, major, 2 or more compartments (e.g., medial or lateral)
Joint Services (Musculoskeletal)	29875	Arthroscopy, knee, surgical; synovectomy, limited (e.g., plica or shelf resection) (separate procedure)
Joint Services (Musculoskeletal)	29874	Arthroscopy, knee, surgical; for removal of loose body or foreign body (e.g., osteochondritis dissecans fragmentation, chondral fragmentation)
Joint Services (Musculoskeletal)	29873	Arthroscopy, knee, surgical; with lateral release
Joint Services (Musculoskeletal)	29871	Arthroscopy, knee, surgical; for infection, lavage and drainage
Joint Services (Musculoskeletal)	29870	Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)
Joint Services (Musculoskeletal)	29868	Arthroscopy, knee, surgical; meniscal transplantation (includes arthrotomy for meniscal insertion), medial or lateral
Joint Services (Musculoskeletal)	29867	Arthroscopy, knee, surgical; osteochondral allograft (e.g., mosaicplasty)
Joint Services (Musculoskeletal)	29866	Arthroscopy, knee, surgical; osteochondral autograft(s) (e.g., mosaicplasty) (includes harvesting of the autograft[s])
Joint Services (Musculoskeletal)	29807	Arthroscopy, shoulder, surgical; repair of SLAP lesion
Joint Services (Musculoskeletal)	29806	Arthroscopy, shoulder, surgical; capsulorrhaphy
Joint Services (Musculoskeletal)	29805	Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)
Joint Services (Musculoskeletal)	27487	Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component
Joint Services (Musculoskeletal)	27486	Revision of total knee arthroplasty, with or without allograft; 1 component
Joint Services (Musculoskeletal)	27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)
Joint Services (Musculoskeletal)	27446	Arthroplasty, knee, condyle and plateau; medial OR lateral compartment
Joint Services (Musculoskeletal)	27443	Arthroplasty, femoral condyles or tibial plateau(s), knee; with debridement and partial synovectomy
Joint Services (Musculoskeletal)	27442	Arthroplasty, femoral condyles or tibial plateau(s), knee;
Joint Services (Musculoskeletal)	27441	Arthroplasty, knee, tibial plateau; with debridement and partial synovectomy
Joint Services (Musculoskeletal)	27440	Arthroplasty, knee, tibial plateau;
Joint Services (Musculoskeletal)	27438	Arthroplasty, patella; with prosthesis
Joint Services (Musculoskeletal)	27430	Quadricepsplasty (e.g., Bennett or Thompson type)
Joint Services (Musculoskeletal)	27429	Ligamentous reconstruction (augmentation), knee; intra-articular (open) and extra-articular
Joint Services (Musculoskeletal)	27428	Ligamentous reconstruction (augmentation), knee; intra-articular (open)
Joint Services (Musculoskeletal)	27427	Ligamentous reconstruction (augmentation), knee; extra- articular
Joint Services (Musculoskeletal)	27425	Lateral retinacular release, open
Joint Services (Musculoskeletal)	27424	Reconstruction of dislocating patella; with patellectomy
Joint Services (Musculoskeletal)	27422	Reconstruction of dislocating patella; with extensor realignment and/or muscle advancement or release (e.g., Campbell, Goldwaite type procedure)
Joint Services (Musculoskeletal)	27420	Reconstruction of dislocating patella; (e.g., Hauser type procedure)
Joint Services (Musculoskeletal)	27418	Anterior tibial tubercleplasty (e.g., Maquet type procedure)
Joint Services (Musculoskeletal)	27416	Osteochondral autograft(s), knee, open (e.g., mosaicplasty) (includes harvesting of autograft[s])
Joint Services (Musculoskeletal)	27415	Osteochondral allograft, knee, open
Joint Services (Musculoskeletal)	27412	Autologous chondrocyte implantation, knee
Joint Services (Musculoskeletal)	27403	Arthrotomy with meniscus repair, knee
Joint Services (Musculoskeletal)	27335	Arthrotomy, with synovectomy, knee; anterior AND posterior including popliteal area
Joint Services (Musculoskeletal)	27334	Arthrotomy, with synovectomy, knee; anterior OR posterior
Joint Services (Musculoskeletal)	27333	Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial AND lateral

Joint Services (Musculoskeletal)	27332	Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial OR lateral
Joint Services (Musculoskeletal)	29828	Arthroscopy, shoulder, surgical; biceps tenodesis
Joint Services (Musculoskeletal)	29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
Joint Services (Musculoskeletal)	29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (i.e., arch) release, when performed (List separately in addition to code for primary procedure)
Joint Services (Musculoskeletal)	29825	Arthroscopy, shoulder, surgical; with lysis and resection of adhesions, with or without manipulation
Joint Services (Musculoskeletal)	29824	Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure)
Joint Services (Musculoskeletal)	29823	Arthroscopy, shoulder, surgical; debridement, extensive
Joint Services (Musculoskeletal)	29822	Arthroscopy, shoulder, surgical; debridement, limited
Joint Services (Musculoskeletal)	29821	Arthroscopy, shoulder, surgical; synovectomy, complete
Joint Services (Musculoskeletal)	29820	Arthroscopy, shoulder, surgical; synovectomy, partial
Joint Services (Musculoskeletal)	29819	Arthroscopy, shoulder, surgical; with removal of loose body or foreign body
Joint Services (Musculoskeletal)	23474	Revision of total shoulder arthroplasty, including allograft when performed; humeral and glenoid component
Joint Services (Musculoskeletal)	23473	Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component
Joint Services (Musculoskeletal)	23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (e.g., total shoulder))
Joint Services (Musculoskeletal)	23470	Arthroplasty, glenohumeral joint; hemiarthroplasty
Joint Services (Musculoskeletal)	23466	Capsulorrhaphy, glenohumeral joint, any type multi-directional instability
Joint Services (Musculoskeletal)	23465	Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block
Joint Services (Musculoskeletal)	23462	Capsulorrhaphy, anterior, any type; with coracoid process transfer
Joint Services (Musculoskeletal)	23460	Capsulorrhaphy, anterior, any type; with bone block
Joint Services (Musculoskeletal)	23455	Capsulorrhaphy, anterior; with labral repair (e.g., Bankart procedure)
Joint Services (Musculoskeletal)	23450	Capsulorrhaphy, anterior; Putti-Platt procedure or Magnuson type operation
Joint Services (Musculoskeletal)	23440	Resection or transplantation of long tendon of biceps
Joint Services (Musculoskeletal)	23430	Tenodesis of long tendon of biceps
Joint Services (Musculoskeletal)	23420	Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)
Joint Services (Musculoskeletal)	23415	Coracoacromial ligament release, with or without acromioplasty
Joint Services (Musculoskeletal)	23412	Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open; chronic
Joint Services (Musculoskeletal)	23410	Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open; acute
Joint Services (Musculoskeletal)	23130	Acromioplasty or acromionectomy, partial, with or without coracoacromial ligament release
Joint Services (Musculoskeletal)	23120	Claviculectomy; partial
Joint Services (Musculoskeletal)	23020	Capsular contracture release (e.g., Sever type procedure)
Joint Services (Musculoskeletal)	23000	Removal of subdeltoid calcareous deposits, open
Medical /Surgical	21110	APPLICATION OF INTERDENTAL FIXATION DEVICE FOR CONDITIONS OTHER THAN FRACTURE OR DISLOCATION, INCLUDES REMOVAL
Medical /Surgical	21497	INTERDENTAL WIRING, FOR CONDITION OTHER THAN FRACTURE
Transplant	38242	BONE MARROW OR BLOOD-DERIVED PERIPHERAL STEM CELL TRANSPLANTATION; ALLOGENEIC DONOR LYMPHOCYTE INFUSIONS
Medical /Surgical	33999	UNLISTED PROCEDURE, CARDIAC SURGERY
Medical /Surgical	36465	INJECTION OF NON-COMPOUNDED FOAM SCLEROSANT WITH ULTRASOUND COMPRESSION MANEUVERS TO GUIDE DISPERSION OF THE INJECTATE, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING; SINGLE INCOMPETENT EXTREMITY TRUNCAL VEIN (EG, GREAT SAPHENOUS VEIN, ACCESSORY SAPHEN
Medical /Surgical	36466	INJECTION OF NON-COMPOUNDED FOAM SCLEROSANT WITH ULTRASOUND COMPRESSION MANEUVERS TO GUIDE DISPERSION OF THE INJECTATE, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING; MULTIPLE INCOMPETENT TRUNCAL VEINS (EG, GREAT SAPHENOUS VEIN, ACCESSORY SAPHENOUS VEI
Medical /Surgical	36470	INJECTION OF SCLEROSING SOLUTION; SINGLE VEIN
Medical /Surgical	36471	INJECTION OF SCLEROSING SOLUTION; MULTIPLE VEINS, SAME LEG
Medical /Surgical	36473	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS, MECHANOCHEMICAL; FIRST VEIN TREATED
Medical /Surgical	36474	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS, MECHANOCHEMICAL; SUBSEQUENT VEIN(S) TREATED IN A SINGLE EXTREMITY, EACH THROUGH SEPARATE ACCESS SITES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
Medical /Surgical	36475	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS RADIOFREQUENCY; FIRST VEIN TREATED
Medical /Surgical	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)
Medical /Surgical	36478	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS, LASER; FIRST VEIN TREATED
Medical /Surgical	36479	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS, LASER; SECOND AND SUBSEQUENT VEINS TREATED IN A SINGLE EXTREMITY, EACH THROUGH SEPARATE ACCESS SITES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
Medical /Surgical	36482	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, BY TRANSCATHETER DELIVERY OF A CHEMICAL ADHESIVE (EG, CYANOACRYLATE) REMOTE FROM THE ACCESS SITE, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS; FIRST VEIN TREATED

Medical /Surgical	36483	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, BY TRANSCATHETER DELIVERY OF A CHEMICAL ADHESIVE (EG, CYANOACRYLATE) REMOTE FROM THE ACCESS SITE, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS; SUBSEQUENT VEIN(S) TREATED IN A SINGLE EXTREMITY, EACH THROUGH SEPARATE ACCESS SITES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
Medical /Surgical	37500	VASCULAR ENDOSCOPY, SURGICAL, WITH LIGATION OF PERFORATOR VEINS, SUBFASCIAL (SEPS)
Medical /Surgical	37700	LIGATION AND DIVISION OF LONG SAPHENOUS VEIN AT SAPHENOFEMORAL JUNCTION, OR DISTAL INTERRUPTIONS
Medical /Surgical	37718	LIGATION, DIVISION, AND STRIPPING, SHORT SAPHENOUS VEIN
Medical /Surgical	37722	LIGATION, DIVISION, AND STRIPPING, LONG (GREATER) SAPHENOUS VEINS FROM SAPHENOFEMORAL JUNCTION TO KNEE OR BELOW
Medical /Surgical	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
Medical /Surgical	37760	LIGATION OF PERFORATOR VEINS, SUBFASCIAL, RADICAL (LINTON TYPE), INCLUDING SKIN GRAFT, WHEN PERFORMED, OPEN,1 LEG
Medical /Surgical	37761	LIGATION OF PERFORATOR VEIN(S), SUBFASCIAL, OPEN, INCLUDING ULTRASOUND GUIDANCE, WHEN PERFORMED, 1 LEG
Medical /Surgical	37765	STAB PHLEBECTOMY OF VARICOSE VEINS, 1 EXTREMITY; 10-20 STAB INCISIONS
Medical /Surgical	37766	STAB PHLEBECTOMY OF VARICOSE VEINS, ONE EXTREMITY; MORE THAN 20 INCISIONS
Medical /Surgical	37780	LIGATION AND DIVISION OF SHORT SAPHENOUS VEIN AT SAPHENOPOPLITEAL JUNCTION (SEPARATE PROCEDURE)
Medical /Surgical	37785	LIGATION, DIVISION, AND/OR EXCISION OF VARICOSE VEIN CLUSTER(S), 1 LEG
Medical /Surgical	S2202	ECHOSCLEROTHERAPY
Medical /Surgical	43284	LAPAROSCOPY, SURGICAL, ESOPHAGEAL SPHINCTER AUGMENTATION PROCEDURE, PLACEMENT OF SPHINCTER AUGMENTATION DEVICE (IE, MAGNETIC BAND), INCLUDING CRUROPLASTY WHEN PERFORMED
Medical /Surgical	43285	REMOVAL OF ESOPHAGEAL SPHINCTER AUGMENTATION DEVICE
Medical /Surgical	49568	IMPLANTATION OF MESH OR OTHER PROSTHESIS FOR OPEN INCISIONAL OR VENTRAL HERNIA REPAIR OR MESH FOR CLOSURE OF DEBRIDEMENT FOR NECROTIZING SOFT TISSUE INFECTION (LIST SEPARATELY IN ADDITION TO CODE FOR THE INCISIONAL OR VENTRAL HERNIA REPAIR)
Medical /Surgical	58150	TOTAL ABDOMINAL HYSTERECTOMY (CORPUS AND CERVIX), WITH OR WITHOUT REMOVAL
Medical /Surgical	58152	TOTAL ABDOMINAL HYSTERECTOMY (CORPUS AND CERVIX), WITH OR WITHOUT REMOVAL
Medical /Surgical	58180	SUPRACERVICAL ABDOMINAL HYSTERECTOMY (SUBTOTAL HYSTERECTOMY), WITH OR
Medical /Surgical	58541	LAPAROSCOPY, SURGICAL, SUPRACERVICAL HYSTERECTOMY, FOR UTERUS 250 G OR LESS;
Medical /Surgical	58542	LAPAROSCOPY, SURGICAL, SUPRACERVICAL HYSTERECTOMY, FOR UTERUS 250 G OR LESS; WITH REMOVAL OF TUBE(S) AND/OR OVARY(S)
Medical /Surgical	58543	LAPAROSCOPY, SURGICAL, SUPRACERVICAL HYSTERECTOMY, FOR UTERUS
Medical /Surgical	58544	LAPAROSCOPY, SURGICAL, SUPRACERVICAL HYSTERECTOMY, FOR UTERUS
Medical /Surgical	58550	LAPAROSCOPY SURGICAL, WITH VAGINAL HYSTERECTOMY, FOR UTERUS 250 GRAMS OR
Medical /Surgical	58552	LAPAROSCOPY SURGICAL, WITH VAGINAL HYSTERECTOMY, FOR UTERUS 250 GRAMS OR LESS; WITH REMOVAL OF TUBE(S) AND/OR OVARY(S)
Medical /Surgical	58553	LAPAROSCOPY SURGICAL, WITH VAGINAL HYSTERECTOMY, FOR UTERUS GREATER THAN
Medical /Surgical	58554	LAPAROSCOPY SURGICAL, WITH VAGINAL HYSTERECTOMY, FOR UTERUS GREATER THAN 250 GRAMS; WITH REMOVAL OF TUBE(S) AND/OR OVARY(S)
Medical /Surgical	58570	LAPAROSCOPY, SURGICAL, WITH TOTAL HYSTERECTOMY, FOR UTERUS
Medical /Surgical	58571	LAPAROSCOPY, SURGICAL, WITH TOTAL HYSTERECTOMY, FOR UTERUS 250 G OR LESS; WITH REMOVAL OF TUBE(S) AND/OR OVARY(S)
Medical /Surgical	58572	LAPAROSCOPY, SURGICAL, WITH TOTAL HYSTERECTOMY, FOR UTERUS
Medical /Surgical	58573	LAPAROSCOPY, SURGICAL, WITH TOTAL HYSTERECTOMY, FOR UTERUS GREATER THAN 250 G; WITH REMOVAL OF TUBE(S) AND/OR OVARY(S)
Medical /Surgical	21899	UNLISTED PROCEDURE, NECK OR THORAX
Medical /Surgical	27437	ARTHROPLASTY, PATELLA; WITHOUT PROSTHESIS
Medical /Surgical	22899	UNLISTED PROCEDURE, SPINE
Medical /Surgical	27599	UNLISTED PROCEDURE, FEMUR OR KNEE
Medical /Surgical	29999	UNLISTED PROCEDURE, ARTHROSCOPY
Medical /Surgical	37799	UNLISTED PROCEDURE, VASCULAR SURGERY
Medical /Surgical	49999	UNLISTED PROCEDURE, ABDOMEN, PERITONEUM AND OMENTUM
Medical /Surgical	58578	UNLISTED LAPAROSCOPY PROCEDURE, UTERUS
Medical /Surgical	58579	UNLISTED HYSTEROSCOPY PROCEDURE, UTERUS
Medical /Surgical	58679	UNLISTED LAPAROSCOPY PROCEDURE, OVIDUCT, OVARY
Medical /Surgical	67999	UNLISTED PROCEDURE, EYELIDS
Medical /Surgical	68899	UNLISTED PROCEDURE, LACRIMAL SYSTEM
Medical /Surgical	D2999	UNSPECIFIED RESTORATIVE PROCEDURE, BY REPORT
Medical /Surgical	64561	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODE ARRAY; SACRAL NERVE (TRANSFORAMINAL PLACEMENT) INCLUDING IMAGE GUIDANCE, IF PERFORMED
Medical /Surgical	64568	INCISION FOR IMPLANTATION OF CRANIAL NERVE (EG, VAGUS NERVE) NEUROSTIMULATOR ELECTRODE ARRAY AND PULSE GENERATOR
Medical /Surgical	64590	INSERTION OR REPLACEMENT OF PERIPHERAL OR GASTRIC NEUROSTIMULATOR PULSE GENERATOR OR RECEIVER, DIRECT OR INDUCTIVE COUPLING
Medical /Surgical	65760	KERATOMILEUSIS
Medical /Surgical	65765	KERATOPHAKIA
Medical /Surgical	65771	RADIAL KERATOTOMY
Medical /Surgical	S0810	PHOTOREFRACTIVE KERATECTOMY (PRK)
Medical /Surgical	21120	GENIOPLASTY; AUGMENTATION (AUTOGRAFT, ALLOGRAFT, PROSTHETIC MATERIAL)
Medical /Surgical	21122	GENIOPLASTY; SLIDING OSTEOTOMIES, TWO OR MORE OSTEOTOMIES (EG, WEDGE EXCISION OR BONE WEDGE REVERSAL FOR ASYMMETRICAL CHIN)

Medical /Surgical	21123	GENIOPLASTY; SLIDING, AUGMENTATION WITH INTERPOSITIONAL BONE GRAFTS (INCLUDES OBTAINING AUTOGRAFTS)
Medical /Surgical	21125	AUGMENTATION, MANDIBULAR BODY OR ANGLE; PROSTHETIC MATERIAL
Medical /Surgical	21127	AUGMENTATION, MANDIBULAR BODY OR ANGLE; WITH BONE GRAFT, ONLAY OR INTERPOSITIONAL (INCLUDES OBTAINING AUTOGRAFT)
Medical /Surgical	67900	REPAIR OF BROW PTOSIS (SUPRACILIARY, MID-FOREHEAD OR CORONAL APPROACH)
Medical /Surgical	67901	REPAIR OF BLEPHAROPTOSIS; FRONTALIS MUSCLE TECHNIQUE WITH SUTURE OR OTHER MATERIAL (EG, BANKED FASCIA)
Medical /Surgical	67902	REPAIR OF BLEPHAROPTOSIS; FRONTALIS MUSCLE TECHNIQUE WITH AUTOLOGOUS FASCIAL SLING (INCLUDES OBTAINING FASCIA)
Medical /Surgical	67903	REPAIR OF BLEPHAROPTOSIS; (TARSO) LEVATOR RESECTION OR ADVANCEMENT, INTERNAL APPROACH
Medical /Surgical	67904	REPAIR OF BLEPHAROPTOSIS; (TARSO) LEVATOR RESECTION OR ADVANCEMENT, EXTERNAL APPROACH
Medical /Surgical	67906	REPAIR OF BLEPHAROPTOSIS; SUPERIOR RECTUS TECHNIQUE WITH FASCIAL SLING (INCLUDES OBTAINING FASCIA)
Medical /Surgical	67908	REPAIR OF BLEPHAROPTOSIS; CONJUNCTIVO-TARSO-MULLER S MUSCLE-LEVATOR RESECTION (EG, FASANELLA-SERVAT TYPE)
Medical /Surgical	67911	CORRECTION OF LID RETRACTION
Surgery (Musculoskeletal)	62287	Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar
Medical /Surgical	20912	CARTILAGE GRAFT; NASAL SEPTUM
Medical /Surgical	30400	RHINOPLASTY, PRIMARY; LATERAL AND ALAR CARTILAGES AND/OR ELEVATION OF NASAL TIP
Medical /Surgical	30410	RHINOPLASTY, PRIMARY; COMPLETE, EXTERNAL PARTS INCLUDING BONY PYRAMID, LATERAL AND ALAR CARTILAGES, AND/OR ELEVATION OF NASAL TIP
Medical /Surgical	30420	RHINOPLASTY, PRIMARY; INCLUDING MAJOR SEPTAL REPAIR
Medical /Surgical	30430	RHINOPLASTY, SECONDARY; MINOR REVISION (SMALL AMOUNT OF NASAL TIP WORK)
Medical /Surgical	30435	RHINOPLASTY, SECONDARY; INTERMEDIATE REVISION (BONY WORK WITH OSTEOTOMIES)
Medical /Surgical	30450	RHINOPLASTY, SECONDARY; MAJOR REVISION (NASAL TIP WORK AND OSTEOTOMIES)
Medical /Surgical	30520	SEPTOPLASTY OR SUBMUCOUS RESECTION, WITH OR WITHOUT CARTILAGE SCORING CONTOURING OR REPLACEMENT WITH GRAFT
Medical /Surgical	31255	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH ETHMOIDECTOMY, TOTAL (ANTERIOR AND POSTERIOR)
Medical /Surgical	69300	OTOPLASTY PROTRUDING EAR, WITH OR WITHOUT SIZE REDUCTION
Medical /Surgical	69714	IMPLANTATION, OSSEOINTEGRATED IMPLANT, TEMPORAL BONE, WITH PERCUTANEOUS ATTACHMENT TO EXTERNAL SPEECH PROCESSOR/COCHLEAR STIMULATOR; WITHOUT MASTOIDECTOMY
Medical /Surgical	69715	IMPLANTATION, OSSEOINTEGRATED IMPLANT, TEMPORAL BONE, WITH PERCUTANEOUS ATTACHMENT TO EXTERNAL SPEECH PROCESSOR/COCHLEAR STIMULATOR; WITH MASTOIDECTOMY
Medical /Surgical	69718	REPLACEMENT (INCLUDING REMOVAL OF EXISTING DEVICE), OSSEOINTEGRATED
Medical /Surgical	69930	COCHLEAR DEVICE IMPLANTATION, WITH OR WITHOUT MASTOIDECTOMY
Medical /Surgical	L8614	COCHLEAR DEVICE, INCLUDES ALL INTERNAL AND EXTERNAL COMPONENTS
Medical /Surgical	L8619	COCHLEAR IMPLANT, EXTERNAL SPEECH PROCESSOR AND CONTROLLER, INTEGRATED SYSTEM, REPLACEMENT
Medical /Surgical	91110	GASTROINTESTINAL TRACT IMAGING, INTRALUMINAL (EG, CAPSULE ENDOSCOPY), ESOPHAGUS THROUGH ILEUM, WITH PHYSICIAN INTERPRETATION AND REPORT
Medical /Surgical	91111	GASTROINTESTINAL TRACT IMAGING, INTRALUMINAL (EG, CAPSULE ENDOSCOPY), ESOPHAGUS WITH INTERPRETATION AND REPORT
Medical /Surgical	92507	TREATMENT OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/OR AUDITORY PROCESSING DISORDER; INDIVIDUAL
Medical /Surgical	92508	TREATMENT OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/OR AUDITORY PROCESSING DISORDER; GROUP, 2 OR MORE INDIVIDUALS
Medical /Surgical	92526	TREATMENT OF SWALLOWING DYSFUNCTION AND/OR ORAL FUNCTION FOR FEEDING
Medical /Surgical	93229	EXTERNAL 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; TECHNICAL SUPPORT FOR CONNECTION AND PATIENT INSTRUCTIONS FOR USE, ATTENDED SURVEILLANCE, ANALYSIS AND TRANSMISSION OF DAILY AND EMERGENT DATA REPORTS AS PRESCRIBED BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL
Medical /Surgical	95807	SLEEP STUDY, SIMULTANEOUS RECORDING OF VENTILATION, RESPIRATORY EFFORT, ECG OR HEART RATE, AND OXYGEN SATURATION, ATTENDED BY A TECHNOLOGIST
Medical /Surgical	95808	POLYSOMNOGRAPHY; ANY AGE, SLEEP STAGING WITH 1-3 ADDITIONAL PARAMETERS OF SLEEP, ATTENDED BY A TECHNOLOGIST
Medical /Surgical	95810	POLYSOMNOGRAPHY; AGE 6 YEARS OR OLDER, SLEEP STAGING WITH 4 OR MORE ADDITIONAL PARAMETERS OF SLEEP, ATTENDED BY A TECHNOLOGIST
Medical /Surgical	95811	POLYSOMNOGRAPHY; AGE 6 YEARS OR OLDER, SLEEP STAGING WITH 4 OR MORE ADDITIONAL PARAMETERS OF SLEEP, WITH INITIATION OF CONTINUOUS POSITIVE AIRWAY PRESSURE THERAPY OR BILEVEL VENTILATION, ATTENDED BY A TECHNOLOGIST
Medical /Surgical	V5281	ASSISTIVE LISTENING DEVICE, PERSONAL FM/DM SYSTEM, MONAURAL, (1 RECEIVER, TRANSMITTER, MICROPHONE), ANY TYPE
Medical /Surgical	V5282	ASSISTIVE LISTENING DEVICE, PERSONAL FM/DM SYSTEM, BINAURAL, (2 RECEIVERS, TRANSMITTER, MICROPHONE), ANY TYPE
Medical /Surgical	V5286	ASSISTIVE LISTENING DEVICE, PERSONAL BLUE TOOTH FM/DM RECEIVER
Medical /Surgical	V5287	ASSISTIVE LISTENING DEVICE, PERSONAL FM/DM RECEIVER, NOT OTHERWISE SPECIFIED

Medical /Surgical	V5288	ASSISTIVE LISTENING DEVICE, PERSONAL FM/DM TRANSMITTER ASSISTIVE LISTENING DEVICE
Medical /Surgical	V5289	ASSISTIVE LISTENING DEVICE, PERSONAL FM/DM ADAPTER/BOOT COUPLING DEVICE FOR RECEIVER, ANY TYPE
Medical /Surgical	33289	TRANSCATHETER IMPLANTATION OF WIRELESS PULMONARY ARTERY PRESSURE SENSOR FOR LONG-TERM HEMODYNAMIC MONITORING, INCLUDING DEPLOYMENT AND CALIBRATION OF THE SENSOR, RIGHT HEART CATHETERIZATION, SELECTIVE PULMONARY CATHETERIZATION, RADIOLOGICAL SUPERVISION AND INTERPRETATION, AND PULMONARY ARTERY ANGIOGRAPHY, WHEN PERFORMED
Transplant	38242	ALLOGENEIC LYMPHOCYTE INFUSIONS
Specialty Surgeries	62287	DECOMPRESSION PROCEDURE, PERCUTANEOUS, OF NUCLEUS PULPOSUS OF INTERVERTEBRAL DISC, ANY METHOD UTILIZING NEEDLE BASED TECHNIQUE TO REMOVE DISC MATERIAL UNDER FLUOROSCOPIC IMAGING OR OTHER FORM OF INDIRECT VISUALIZATION, WITH DISCOGRAPHY AND/OR EPIDURAL INJ
Reconstructive /Possibly Cosmetic (Medical / Surgical)	G0429	DERMAL FILLER INJECTION(S) FOR THE TREATMENT OF FACIAL LIPODYSTROPHY SYNDROME (LDS) (E.G., AS A RESULT OF HIGHLY ACTIVE ANTIRETROVIRAL THERAPY)
Site of Care	J0256	INJECTION, ALPHA 1 PROTEINASE INHIBITOR (HUMAN) (ARALAST)
Site of Care	J0256	INJECTION, ALPHA 1 PROTEINASE INHIBITOR (HUMAN) (ZEMAIRA)
Site of Care	J0256	INJECTION, ALPHA-1 PROTEINASE INHIBITOR (HUMAN) (PROLASTIN)
Other	J0897	INJECTION, DENOSUMAB, 1 MG (PROLIA)
Other	J0897	INJECTION, DENOSUMAB, 1 MG (XGEVA)
Other	J1325	INJECTION, EPOPROSTENOL, 0.5 MG (FLOLAN)
Other	J1325	INJECTION, EPOPROSTENOL, 0.5 MG (VELETRI)
Site of Care	J1566	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, LYOPHILIZED (E.G., POWDER), 500 MG (CARIMUNE NF)
Site of Care	J1566	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, LYOPHILIZED (E.G., POWDER), 500 MG (GAMMAGARD S/D)
NOC Oncology	NOC**	BEVACIZUMAB-MALY (ALYMSYS)
NOC Oncology	NOC**	TEBENTAFUSP-TEBN (KIMMTRAK)
NOC Oncology	NOC**	NIVOLUMAB/RELATLIMAB-RMBW (OPDUALAG)
NOC Oncology	NOC**	CILTACABTAGENE AUTOLEUCEL (CARVYKTI)
NOC Other	NOC**	ALIROCUMAB (PRALUENT)
NOC Other	NOC**	EVOLOCUMAB (REPATHA)
NOC Other	NOC**	PEGFILGRASTIM-PBBK (FYLNETRA)
Oncology	C9076	LISOCABTAGENE MARALEUCEL, UP TO 110 MILLION AUTOLOGOUS ANTI-CD19 CAR-POSITIVE VIABLE T CELLS, INCLUSING LEUKAPHERESIS AND DOSE PREPARATION PROCEDURES, PER THERAPEUTIC DOSE (BREYANZI)
Oncology	C9095	INJECTION, TEBENTASFUSP-TEBN, 1 MCG (KIMMTRAK)
Oncology	C9098	AUTOLOGOUS B-CELL MATURATION ANTIGEN (BCMA) DIRECTED CAR-POSITIVE T CELLS, INCLUDING LEUKAPHERESIS AND DOSE PREPARATION PROCEDURES, PER THERAPEUTIC DOSE (CARVYKTI)
Oncology	J1448	INJECTION, TRILACICLIB, 1 MG (COSELA)
Oncology	J1930	INJECTION, LANREOTIDE, 1 MG (SOMATULINE DEPOT)
Oncology	J1932	INJECTION, LANREOTIDE, (CIPLA), 1 MG
Oncology	J1950	INJECTION, LEUPROLIDE ACETATE (FOR DEPOT SUSPENSION), PER 3.75 MG
Oncology	J1952	LEUPROLIDE INJECTABLE, CAMCEVI, 1 MG
Oncology	J2860	INJECTION, SILTUXIMAB (SYLVANT)
Oncology	J9019	INJECTION, ASPARAGINASE (ERWINAZE), 1,000 IU
Oncology	J9021	INJECTION, ASPARAGINASE, RECOMBINANT, (RYLAZE), 0.1 MG
Oncology	J9022	INJECTION, ATEZOLIZUMAB, 10 MG (TECENTRIQ)
Oncology	J9023	INJECTION, AVELUMAB, 10 MG (BAVENCIO)
Oncology	J9032	INJECTION, BELINOSTAT, 10 MG (BELEODAQ)
Oncology	J9033	INJECTION, BENDAMUSTINE HCL, 1 MG (TREANDA)
Oncology	J9034	INJECTION, BENDAMUSTINE HCL (BENDEKA), 1 MG
Oncology	J9035	INJECTION, BEVACIZUMAB 10 MG (AVASTIN)
Oncology	J9036	INJECTION, BENDAMUSTINE HYDROCHLORIDE, 1 MG (BELRAPZO)
Oncology	J9037	INJECTION, BELANTAMAB MAFODONTIN-BLMF, 0.5 MG (BLENREP)
Oncology	J9039	INJECTION, BLINATUMOMAB, 1 MICROGRAM (BLINCYTO)
Oncology	J9041	INJECTION, BORTEZOMIB, 0.1 MG (VELCADE)
Oncology	J9042	INJECTION, BRENTUXIMAB VEDOTIN, 1 MG (ADCETRIS)
Oncology	J9044	INJECTION, BORTEZOMIB, NOT OTHERWISE SPECIFIED, 0.1 MG
Oncology	J9047	INJECTION, CARFILZOMIB, 1 MG (KYPROLIS)
Oncology	J9055	INJECTION, CETUXIMAB, 10 MG (ERBITUX)
Oncology	J9061	INJECTION, AMIVANTAMAB-VMJW, 2 MG (RYBREVANT)
Oncology	J9098	INJECTION, CYTARABINE LIPOSOME, 10 MG (DEPOCYT)
Oncology	J9118	INJECTION, CALASPARGASE PEGOL-MKNL, 10 UNITS (ASPARLAS)
Oncology	J9119	INJECTION, CEMIPLIMAB-RWLC, 1 MG (LIBTAYO)
Oncology	J9144	INJECTION, DARATUMUMAB, 10MG AND HYALURONIDASE-FIHJ (DARZALEX FASPRO)
Oncology	J9145	INJECTION, DARATUMUMAB, 10 MG (DARZALEX)
Oncology	J9173	INJECTION, DURVALUMAB, 10 MG (IMFINZI)
Oncology	J9177	INJECTION, ENFORTUMAB VEDOTIN-EJFV, 0.25 MG (PADCEV)
Oncology	J9205	INJECTION, IRINOTECAN LIPOSOME, 1 MG (ONIVYDE)
Oncology	J9210	INJECTION, EMAPALUMAB-LZSG, 1MG (GAMIFANT)
Oncology	J9225	HISTRELIN IMPLANT (VANTAS), 50 MG
Oncology	J9227	INJECTION, ISATUXIMAB-IRFC, 10 MG (SARCLISA)
Oncology	J9228	INJECTION, IPILIMUMAB, 1 MG (YERVOY)
Oncology	J9229	INJECTION, INOTUZUMAB OZOGAMICIN, 0.1 MG (BESPONSA)
Oncology	J9247	INJECTION, MELPHALAN FLUFENAMIDE, 1 MG (PEPAXTO)
Oncology	J9266	INJECTION, PEGASPARGASE, PER SINGLE DOSE VIAL (ONCASPAR)
Oncology	J9269	INJECTION, TAGRAXOFUSP-ERZS, 10 MCG (ELZONRIS)
Oncology	J9271	INJECTION, PEMBROLIZUMAB, 1 MG (KEYTRUDA)

**Select new-to-market drugs with not otherwise classified (NOC) HCPCS codes (e.g. J3490, J3590, J9999, C9399) will require prior authorization, pending unique HCPCS assignment by CMS

Oncology	J9272	INJECTION, DOSTARLIMAB--GXLY, 10 MG (JEMPERLI)
Oncology	J9273	INJECTION, TISOTUMAB VEDOTIN-TFTV, 1 MG (TIVDAK)
Oncology	J9295	INJECTION, NECITUMUMAB, 1 MG (PORTRAZZA)
Oncology	J9299	INJECTION, NIVOLUMAB, 1 MG (OPDIVO)
Oncology	J9301	INJECTION, OBINUTUZUMAB, 10 MG (GAZYVA)
Oncology	J9303	INJECTION, PANITUMUMAB, 10 MG (VECTIBIX)
Oncology	J9306	INJECTION, PERTUZUMAB, 1 MG (PERJETA)
Oncology	J9308	INJECTION, RAMUCIRUMAB, 5 MG (CYRAMZA)
Oncology	J9309	INJECTION, POLATUZUMAB VEDOTIN-PIIQ, 1 MG (POLIVY)
Oncology	J9311	INJECTION, RITUXIMAB 10 MG AND HYALURONIDASE (RITUXAN HYCELA)
Oncology	J9312	INJECTION, RITUXIMAB, 10 MG (RITUXAN)
Oncology	J9316	INJECTION, PERTUZUMAB, TRASTUZUMAB, AND HYALURONIDASE-ZZXF, PER 10MG (PHESGO)
Oncology	J9317	INJECTION, SACITUZUMAB GOVITECAN-HZIY, 2.5 MG (TRODELVY)
Oncology	J9330	INJECTION, TEMSIROLIMUS, 1 MG (TORISEL)
Oncology	J9331	INJECTION SIROLIMUS PROTEIN-BOUND PARTICLES, 1 MG (FYARRO)
Oncology	J9349	INJECTION, TAFASITAMAB-CXIX, 2MG (MONJUVI)
Oncology	J9353	INJECTION, MARGETUXIMAB-CMKB, 5 MG (MARGENZA)
Oncology	J9354	INJECTION, ADO-TRASTUZUMAB EMTANSINE, 1 MG (KADCYLA)
Oncology	J9355	INJECTION, TRASTUZUMAB, 10 MG (HERCEPTIN)
Oncology	J9356	INJECTION, TRASTUZUMAB, AND HYALURONIDASE-OYSK (HERCEPTIN HYLECTRA) 10 MG
Oncology	J9358	INJECTION, FAM-TRASTUZUMAB DERUXTECAN-NXKI, 1 MG (ENHERTU)
Oncology	J9359	INJECTION, LONCASTUXIMAB TESIRINE-LPYL, 0.075 MG (ZYNLONTA)
Oncology	J9395	INJECTION, FULVESTRANT, 25 MG (FASLODEX)
Oncology	J9999	NOT OTHERWISE CLASSIFIED, ANTINEOPLASTIC DRUGS
Oncology	Q2041	AXICABTAGENE CILOLEUCEL, UP TO 200 MILLION AUTOLOGOUS ANTI-CD19 CAR T CELLS, INCLUDING LEUKAPHERESIS AND DOSE PREPARATION PROCEDURES, PER INFUSION (YESCARTA)
Oncology	Q2042	TISAGENLECLEUCEL, UP TO 600 MILLION CAR-POSITIVE VIABLE T CELLS, INCLUDING LEUKAPHERESIS AND DOSE PREPARATION PROCEDURES, PER THERAPEUTIC DOSE (KYMRIAH)
Oncology	Q2043	SIPULEUCEL-T, MINIMUM OF 50 MILLION AUTOLOGOUS CD54+ CELLS ACTIVATED WITH PAP-GM-CSF, INCLUDING LEUKAPHERESIS AND ALL OTHER PREPARATORY PROCEDURES, PER INFUSION (PROVENGE)
Oncology	Q2053	BREXUCABTAGENE AUTOLEUCEL, UP TO 200 MILLION AUTOLOGOUS ANIT-CD 19 CAR POSITIVE VIABLE T-CELLS, INCLUDING LEUKAPHERESIS AND DOSE PREPARATION PROCEDURES, PER THERAPEUTIC DOSE (TECARUS)
Oncology	Q2054	LISOCABTAGENE MARALEUCEL, UP TO 110 MILLION AUTOLOGOUS ANTI-CD19 CAR-POSITIVE VIABLE T CELLS, INCLUSING LEUKAPHERESIS AND DOSE PREPARATION PROCEDURES, PER THERAPEUTIC DOSE (BREYANZI)
Oncology	Q2055	IDECABTAGENE VICLEUCEL, UP TO 460 MILLION AUTOLOGOUS B-CELL MATURATION ANTIGEN (BCMA) DIRECTED CAR-POSITIVE T CELLS, INCLUDING LEUKAPHERESIS AND DOSE PREPARATION PROCEDURES, PER THERAPEUTIC DOSE (ABCEMA)
Oncology	Q5107	INJECTION, BEVACIZUMAB-AWWB, BIOSIMILAR, (MVASI), 10 MG
Oncology	Q5112	INJECTION, TRASTUZUMAB-DTTB, BIOSIMILAR, (ONTRUZANT), 10 MG
Oncology	Q5113	INJECTION, TRASTUZUMAB-PKRB, BIOSIMILAR, (HERZUMA), 10 MG
Oncology	Q5114	INJECTION, TRASTUZUMAB-DKST, BIOSIMILAR, (OGIVRI), 10 MG
Oncology	Q5115	INJECTION, RITUXIMAB-ABBS, BIOSIMILAR, (TRUXIMA), 10 MG
Oncology	Q5116	INJECTION, TRASTUZUMAB-QYYP, BIOSIMILAR, (TRAZIMERA), 10 MG
Oncology	Q5117	INJECTION, TRASTUZUMAB-ANNS, BIOSIMILAR, (KANJINTI), 10 MG
Oncology	Q5118	INJECTION, BEVACIZUMAB-BVZR, BIOSIMILIAR, (ZIRABEV), 10 MG
Oncology	Q5119	INJECTION, RITUXIMAB-PVVR, BIOSIMILAR, (RUXIENCE), 10 MG
Oncology	Q5123	INJECTION, RETUXIMAB-ARRX, BIOSIMILAR, (RIABNI), 10 MG
Other	90378	RESPIRATORY SYNCYTIAL VIRUS, MONOCLONAL ANTIBODY, RECOMBINANT, FOR INTRAMUSCULAR USE, 50 MG, EACH (SYNAGIS)
Other	C9075	INJECTION, CASIMERSEN, 10 MG (AMONDYS 45)
Other	C9090	INJECTION, PLASMINOGEN, HUMAN-TVMH, 1 MG (RYPLAZIM)
Other	C9094	INJECTION, SUTIMLIMAB-JOME, 10 MG (ENJAYMO)
Other	C9097	INJECTION, FARICIMAB-SVOA, 0.1 MG (VABYSMO)
Other	C9399	UNCLASSIFIED DRUGS OR BIOLOGICALS
Other	J0172	INJECTION, ADUCANUMAB-AVWA, 2 MG (ADUHELM)
Other	J0178	INJECTION, AFLIBERCEPT, 1 MG (EYLEA)
Other	J0179	INJECTION, BROLUCIZUMAB-DBLL, 1 MG (BEOVU)
Other	J0202	INJECTION, ALEMTUZUMAB, 1 MG (LEMTRADA)
Other	J0223	INJECTION, GIVOSIRAN, 0.5 MG (GIVLAARI)
Other	J0224	INJECTION, LUMASIRAN, 0.5 MG (OXLUMO)
Other	J0480	INJECTION, BASILIXIMAB, 20 MG (SIMULECT)
Other	J0517	INJECTION, BENRALIZUMAB, 1 MG (FASENRA)
Other	J0565	INJECTION, BEZLOTOXUMAB, 10 MG (ZINPLAVA)
Other	J0567	INJECTION, CERLIPONASE ALFA, 1 MG (BRINEURA)
Other	J0585	INJECTION, ONABOTULINUMTOXINA, 1 UNIT BOTULINUM TOXIN TYPE A, PER UNIT) (BOTOX)
Other	J0586	INJECTION, ABOBOTULINUMTOXINA, 5 UNITS (DYSPORT)
Other	J0587	INJECTION, RIMABOTULINUMTOXINB, 100 UNITS BOTULINUM TOXIN TYPE B, PER 100 UNITS (MYOBLOC)
Other	J0588	INJECTION, INCOBOTULINUMTOXIN A, 1 UNIT (XEOMIN)
Other	J0593	INJECTION, LANADELUMAB-FLYO, 1 MG (TAKHZYRO)
Other	J0599	INJECTION, C-1 ESTERASE INHIBITOR (HUMAN), HAEGARDA, 10 UNITS
Other	J0630	INJECTION, CALCITONIN SALMON, UP TO 400 UNITS (MIACALCIN)
Other	J0638	INJECTION, CANAKINUMAB, 1 MG (ILARIS)

Other	J0717	INJECTION, CERTOLIZUMAB PEGOL, 1 MG (CODE MAY BE USED FOR MEDICARE WHEN DRUG ADMINISTERED UNDER THE DIRECT SUPERVISION OF A PHYSICIAN, NOT FOR USE WHEN DRUG IS SELF ADMINISTERED) (CIMZIA)
Other	J0800	INJECTION, CORTICOTROPIN, UP TO 40 UNITS (H.P. ACTHAR GEL, REPOSITORY CORTICOTROPIN INJECTION
Other	J0896	INJECTION, LUSPATERCEPT-AAMT, 0.25 MG (REBLOZYL)
NOC Other	NOC**	LEUPROLIDE ACETATE FOR DEPOT SUSPENSION (LUPANETA PACK)
NOC Other	NOC**	FARICIMAB-SVOA (VABYSMO)
Other	J1290	INJECTION, ECALLANTIDE, 1 MG (KALBITOR)
Other	J1306	INJECTION, INCLISIRAN, 1 MG (LEQVIO)
NOC Other	NOC**	RISANKIZUMAB-RZAA (SKYRIZI)
NOC Other	NOC**	RANIBIZUMAB-EQURN (CIMERLI)
Other	J1426	INJECTION, CASIMERSEN, 10 MG (AMONDYS 45)
Other	J1427	INJECTION, VILTOLARSEN, 10 MG (VILTEPSO)
Other	J1428	INJECTION, ETEPLIRSEN, 10 MG (EXONDYS 51)
Other	J1429	INJECTION, GOLODIRSEN, 10 MG (VYONDYS 53)
Other	J1555	INJECTION, IMMUNE GLOBULIN (CUVITRU), 100 MG
Other	J1558	INJECTION, IMMUNE GLOBULIN (XEMBIFY), 100 MG
Other	J1559	INJECTION, IMMUNE GLOBULIN 100 MG (HIZENTRA)
Other	J1575	INJECTION, IMMUNE GLOBULIN/HYALURONIDASE, (HYQVIA), 100 MG IMMUNOGLOBULIN
Other	J1632	INJECTION, BREXANOLONE, 1 MG (ZULRESSO)
Other	J1726	INJECTION, HYDROXYPROGESTERONE CAPROATE, 10 MG (MAKENA)
Other	J1729	INJECTION, HYDROXYPROGESTERONE CAPROATE, NOT OTHERWISE SPECIFIED, 10 MG
Other	J1744	INJECTION, ICATIBANT, 1 MG (FIRAZYR)
Other	J1746	INJECTION, IBALIZUMAB-UIYK, 1- MG (TROGARZO)
Other	J2182	INJECTION, MEPOLIZUMAB, 1 MG (NUCALA)
Other	J2323	INJECTION, NATALIZUMAB, 1 MG (TYSABRI)
Other	J2326	INJECTION, NUSINERSEN, 0.1 MG (SPINRAZA)
Other	J2353	INJECTION, OCTREOTIDE, DEPOT FORM FOR INTRAMUSCULAR INJECTION, 1 MG (SANDOSTATIN LAR)
Other	J2356	INJECTION, TEZEPELUMAB-EKKO, 1 MG (TEZSPIRE)
Other	J2357	INJECTION, OMALIZUMAB, 5 MG (XOLAIR)
Other	J2469	INJECTION, PALONOSETRON HCL, 25 MCG (ALOXI)
Other	J2503	INJECTION, PEGAPTANIB SODIUM, 0.3 MG (MACUGEN)
Other	J2506	INJECTION, PEGFILGRASTIM, 6 MG (NEULASTA)
Other	J2507	INJECTION, PEGLOTICASE, 1 MG (KRYSTEXXA)
Other	J2778	INJECTION, RANIBIZUMAB, 0.1 MG (LUCENTIS)
Other	J2779	INJECTION, RANIBIZUMAB, VIA INTRVITREAL IMPLANT (SUSVIMO), 0.1 MG
Other	J2786	INJECTION, RESLIZUMAB, 1 MG (CINQAIR)
Other	J2820	INJECTION, SARGRAMOSTIM (GM-CSF), 50 MCG (LEUKINE)
Other	J2941	INJECTION, SOMATROPIN, 1MG
Other	J2998	INJECTION, PLASMINOGEN, HUMAN-TVMH, 1 MG (RYPLAZIM)
Other	J3111	INJECTION, ROMOSOZUMAB-AQG, 1 MG (EVENITY)
Other	J3285	INJECTION, TREPROSTINIL, 1 MG (REMODULIN)
Other	J3316	INJECTION, TRIPTORELIN, EXTENDED-RELEASE, 3.75 MG (TRIPTODUR)
Other	J3357	USTEKINUMAB, FOR SUBCUTANEOUS INJECTION, 1 MG (STELARA)
Other	J3358	USTEKINUMAB, FOR INTRAVENOUS INJECTION, 1 MG (STELARA)
Other	J3398	INJECTION, VORETIGENE NEPARVOVEC-RZYL, 1 BILLION VECTOR GENOME (LUXTURNA)
Other	J3399	INJECTION, ONASEMNOGENE ABEPARVOVEC-XIOI, PER TREATMENT, UP TO 5X1015 VECTOR GENOMES (ZOLGENSMA)
Other	J3590	UNCLASSIFIED BIOLOGICS
Other	J7313	INJECTION, FLUOCINOLONE ACETONIDE, INTRAVITREAL IMPLANT, 0.01 MG
Other	J7316	INJECTION, OCRIPLASMIN, 0.125 MG (JETREA)
Other	J7320	HYALURONAN OR DERIVITIVE, GENVISC 850, FOR INTRA-ARTICULAR INJECTION, 1 MG
Other	J7322	HYALURONAN OR DERIVATIVE, HYMOVIS, FOR INTRA-ARTICULAR INJECTION, 1 MG
Other	J7324	HYALURONAN OR DERIVATIVE, ORTHOVISC, FOR INTRA-ARTICULAR INJECTION, PER DOSE
Other	J7325	HYALURONAN OR DERIVATIVE, SYNVISC OR SYNVISC-ONE, FOR INTRA-ARTICULAR INJECTION, 1 MG
Other	J7326	HYALURONAN OR DERIVATIVE, GEL-ONE, FOR INTRA-ARTICULAR INJECTION, PER DOSE
Other	J7327	HYALURONAN OR DERIVATIVE, MONOVISC, FOR INTRA-ARTICULAR INJECTION, PER DOSE
Other	J7329	HYALURONAN OR DERIVATIVE, TRIVISC, FOR INTRA-ARTICULAR INJECTION, 1 MG
Other	J7639	DORNASE ALFA, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM
Other	J7682	TOBRAMYCIN, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED UNIT DOSE FORM, ADMINISTERED THROUGH DME, PER 300 MILLIGRAMS (KITABIS, TOBI, BETHKIS)
Other	J7686	TREPROSTINIL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 1.74 MG (TYVASO)
Other	Q5108	INJECTION, PEGFILGRASTIME-JMDB, BIOSIMILAR, (FULPHILA), 0.5 MG
Other	Q5111	INJECTION PEGFILGRASTIME-CBQV, BIOSIMILAR (UDENYCA), 0.5 MG
Other	Q5120	INJECTION, PEGFILGRASTIM-BMEZ, BIOSIMILAR, (ZIEXTENZO), 0.5 MG
Other	Q5122	INJECTION, PEGFILGRASTIM-APGF, BIOSIMILAR, (NYVEPRIA), 0.5 MG
Other	Q5124	INJECTION, RANIBIZUMAB-NUNA, BIOSILIMAR, (BYOOVIZ), 0.1 MG
Outpatient	H0012	ALCOHOL AND/OR DRUG SERVICES; SUB-ACUTE DETOXIFICATION (RESIDENTIAL ADDICTION PROGRAM OUTPATIENT)
Outpatient	H0013	ALCOHOL AND/OR DRUG SERVICES; ACUTE DETOXIFICATION (RESIDENTIAL ADDICTION PROGRAM OUTPATIENT)
Outpatient	H0017	BEHAVIORAL HEALTH; RESIDENTIAL (HOSPITAL RESIDENTIAL TREATMENT PROGRAM), WITHOUT ROOM AND BOARD, PER DIEM
Outpatient	H0018	BEHAVIORAL HEALTH; SHORT-TERM RESIDENTIAL (NONHOSPITAL RESIDENTIAL TREATMENT PROGRAM), WITHOUT ROOM AND BOARD, PER DIEM

Outpatient	H0019	BEHAVIORAL HEALTH; LONG-TERM RESIDENTIAL (NONMEDICAL, NONACUTE CARE IN A RESIDENTIAL TREATMENT PROGRAM WHERE STAY IS TYPICALLY LONGER THAN 30 DAYS), WITHOUT ROOM AND BOARD, PER DIEM
Outpatient	H0022	ALCOHOL AND/OR DRUG INTERVENTION SERVICE (PLANNED FACILITATION)
Outpatient	H0043	SUPPORTED HOUSING, PER DIEM
Outpatient	H0047	ALCOHOL AND/OR OTHER DRUG ABUSE SERVICES, NOT OTHERWISE SPECIFIED
Outpatient	H2001	REHABILITATION PROGRAM, PER 1/2 DAY
Outpatient	H2012	BEHAVIORAL HEALTH DAY TREATMENT, PER HOUR
Outpatient	H2013	PSYCHIATRIC HEALTH FACILITY SERVICE, PER DIEM
Outpatient	H2022	COMMUNITY-BASED WRAP-AROUND SERVICES, PER DIEM
Outpatient	H2036	ALCOHOL AND/OR OTHER DRUG TREATMENT PROGRAM, PER DIEM
Outpatient	T2048	BEHAVIORAL HEALTH; LONG-TERM CARE RESIDENTIAL (NON-ACUTE CARE IN A RESIDENTIAL TREATEMENT PROGRAM WHERE STAY IS TYPICALLY LONGER THAN 30 DAYS), WITH ROOM AND BOARD, PER DIEM
Prosthetics & Orthotics	21089	UNLISTED MAXILLOFACIAL PROSTHETIC PROCEDURE
Prosthetics & Orthotics	L1840	KNEE ORTHOSIS (KO), DEROTATION, MEDIAL-LATERAL, ANTERIOR CRUCIATE LIGAMENT, CUSTOM FABRICATED
Prosthetics & Orthotics	L1844	KNEE ORTHOSIS (KO), SINGLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, CUSTOM FABRICATED
Prosthetics & Orthotics	L1846	KNEE ORTHOSIS (KO), DOUBLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLY CENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, CUSTOMER FABRICATED
Prosthetics & Orthotics	L2005	KNEE-ANKLE-FOOT ORTHOSIS (KAFO) ANY MATERIAL, SINGLE OR DOUBLE UPRIGHT, STANCE CONTROL, AUTOMATIC LOCK AND SWING PHASE RELEASE, ANY TYPE ACTIVATION, INCLUDES ANKLE JOINT, ANY TYPE, CUSTOM FABRICATED
Prosthetics & Orthotics	L3570	ORTHOPEDIC SHOE ADDITION, SPECIAL EXTENSION TO INSTEP (LEATHER WITH EYELETS)
Prosthetics & Orthotics	L3971	SHOULDER ELBOW WRIST HAND ORTHOSIS, SHOULDER CAP DESIGN, INCLUDES ONE OR MORE NONTORSION JOINTS, ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT
Prosthetics & Orthotics	L3975	SHOULDER ELBOW WRIST HAND FINGER ORTHOSIS, SHOULDER CAP DESIGN, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT
Prosthetics & Orthotics	L3976	SHOULDER ELBOW WRIST HAND FINGER ORTHOSIS, ABDUCTION POSITIONING (AIRPLANE DESIGN), THORACIC COMPONENT AND SUPPORT BAR, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT
Prosthetics & Orthotics	L3977	SHOULDER ELBOW WRIST HAND FINGER ORTHOSIS, SHOULDER CAP DESIGN, INCLUDES ON OR MORE NONTORSION JOINTS, ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT
Prosthetics & Orthotics	L5610	ADDITION TO LOWER EXTREMITY, ENDOSKELETAL SYSTEM, ABOVE KNEE, HYDRACADENCE SYSTEM
Prosthetics & Orthotics	L5616	ADDITION TO LOWER EXTREMITY, ENDOSKELETAL SYSTEM, ABOVE KNEE (AK) UNIVERSAL MULTIPLEX SYSTEM, FRICTION SWING PHASE CONTROL
Prosthetics & Orthotics	L5638	ADDITION TO LOWER EXTREMITY, BELOW KNEE, LEATHER SOCKET
Prosthetics & Orthotics	L5639	ADDITION TO LOWER EXTREMITY, BELOW KNEE, WOOD SOCKET
Prosthetics & Orthotics	L5642	ADDITION TO LOWER EXTREMITY, ABOVE KNEE, LEATHER SOCKET
Prosthetics & Orthotics	L5644	ADDITION TO LOWER EXTREMITY, ABOVE KNEE, WOOD SOCKET
Prosthetics & Orthotics	L5651	ADDITION TO LOWER EXTREMITY, ABOVE KNEE (AK), FLEXIBLE INNER SOCKET, EXTERNAL FRAME
Prosthetics & Orthotics	L5683	ADDITION TO LOWER EXTREMITY, BELOW KNEE (BK)/ABOVE KNEE (AK), 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
Prosthetics & Orthotics	L5714	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, VARIABLE FRICTION SWING PHASE CONTROL (SAFETY KNEE)
Prosthetics & Orthotics	L5722	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, PNEUMATIC SWING, FRICTION STANCE PHASE CONTROL
Prosthetics & Orthotics	L5724	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FLUID SWING PHASE CONTROL
Prosthetics & Orthotics	L5780	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, PNEUMATIC/HYDRA PNEUMATIC SWING PHASE CONTROL
Prosthetics & Orthotics	L5795	ADDITION, EXOSKELETAL SYSTEM, HIP DISARTICULATION, ULTRA-LIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)
Prosthetics & Orthotics	L5857	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE-SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, SWING PHASE ONLY, INCLUDES ELECTRONIC SENSOR(S) ANY TYPE
Prosthetics & Orthotics	L5858	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, STANCE PHASE ONLY, INCLUDES ELECTRONIC SENSOR(S), ANY TYPE
Prosthetics & Orthotics	L6020	PARTIAL HAND, NO FINGER REMAINING
Prosthetics & Orthotics	L6120	BELOW ELBOW, MOLDED DOUBLE WALL SPLIT SOCKET, STEP-UP HINGES, HALF CUFF
Prosthetics & Orthotics	L6130	BELOW ELBOW, MOLDED DOUBLE WALL SPLIT SOCKET, STUMP ACTIVATED LOCKING HINGE, HALF CUFF
Prosthetics & Orthotics	L6310	SHOULDER DISARTICULATION, PASSIVE RESTORATION (COMPLETE PROSTHESIS)
Prosthetics & Orthotics	L6320	SHOULDER DISARTICULATION, PASSIVE RESTORATION (SHOULDER CAP ONLY)
Prosthetics & Orthotics	L6350	INTERSCAPULAR THORACIC, MOLDED SOCKET, SHOULDER BULKHEAD, HUMERAL SECTION INTERNAL LOCKING ELBOW, FOREARM
Prosthetics & Orthotics	L6360	INTERSCAPULAR THORACIC, PASSIVE RESTORATION (COMPLETE PROSTHESIS)

Prosthetics & Orthotics	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
Prosthetics & Orthotics	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
Prosthetics & Orthotics	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
Prosthetics & Orthotics	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
Prosthetics & Orthotics	L6625	UPPER EXTREMITY ADDITION, ROTATION WRIST UNIT WITH CABLE LOCK
Prosthetics & Orthotics	L6642	UPPER EXTREMITY ADDITION, EXCURSION AMPLIFIER, LEVER TYPE
Prosthetics & Orthotics	L6647	UPPER EXTREMITY ADDITION, SHOULDER LOCK MECHANISM, BODY POWERED ACTUATOR
Prosthetics & Orthotics	L6648	UPPER EXTREMITY ADDITION, SHOULDER LOCK MECHANISM, EXTERNAL POWERED ACTUATOR
Prosthetics & Orthotics	L6677	UPPER EXTREMITY ADDITION, HARNESS, TRIPLE CONTROL, SIMULTANEOUS OPERATION OF TERMINAL DEVICE AND ELBOW
Prosthetics & Orthotics	L6885	REPLACEMENT SOCKET, SHOULDER DISARTICULATION/INTERSCAPULAR THORACIC, MOLDED TO PATIENT MODEL, FOR USE WITH OR WITHOUT EXTERNAL POWER
Prosthetics & Orthotics	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
Prosthetics & Orthotics	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
Prosthetics & Orthotics	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
Prosthetics & Orthotics	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
Prosthetics & Orthotics	L6945	ELBOW DISARTICULATION, EXTERNAL POWER, MOLDED INNER SOCKET, REMOVABLE HUMERAL SHELL, OUTSIDE LOCKING HINGES, FOREARM, OTTO BOCK OR EQUAL ELECTRODES, CABLES, 2 BATTERIES AND ONE CHARGER, MYOELECTRONIC CONTROL OF TERMINAL DEVICE
Prosthetics & Orthotics	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
Prosthetics & Orthotics	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
Prosthetics & Orthotics	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 CONT
Prosthetics & Orthotics	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
Prosthetics & Orthotics	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 CONT
Prosthetics & Orthotics	L7040	PREHENSILE ACTUATOR, SWITCH CONTROLLED
Prosthetics & Orthotics	L7045	ELECTRIC HOOK, SWITCH OR MYOELECTRIC CONTROLLED, PEDIATRIC
Prosthetics & Orthotics	L7170	ELECTRONIC ELBOW, HOSMER OR EQUAL, SWITCH CONTROLLED
Prosthetics & Orthotics	L7180	ELECTRONIC ELBOW, MICROPROCESSOR SEQUENTIAL CONTROL OF ELBOW AND TERMINAL DEVICE
Prosthetics & Orthotics	L7181	ELECTRONIC ELBOW, MICROPROCESSOR SIMULTANEOUS CONTROL OR ELBOW AND TERMINAL DEVICE
Prosthetics & Orthotics	L7185	ELECTRONIC ELBOW, ADOLESCENT, VARIETY VILLAGE OR-EQUAL, SWITCH CONTROLLED
Prosthetics & Orthotics	L7186	ELECTRONIC ELBOW, CHILD, VARIETY VILLAGE OR EQUAL, SWITCH CONTROLLED
Prosthetics & Orthotics	L7190	ELECTRONIC ELBOW, VARIETY VILLAGE OR EQUAL, MYOELECTRONICALLY CONTROLLED
Prosthetics & Orthotics	L7191	ELECTRONIC ELBOW CHILD, VARIETY VILLAGE OR EQUAL, MYOELECTRONICALLY CONTROLLED
Prosthetics & Orthotics	L8699	PROSTHETIC IMPLANT, NOT OTHERWISE SPECIFIED
PT/OT/ Chiropractic (Physical Medicine)	G0283	Electrical stimulation (unattended), to one or more areas for indication (s) other than wound care, as part of a therapy plan of care (prior authorization required effective 2/1/2020)
PT/OT/ Chiropractic (Physical Medicine)	G0515	Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact, each 15 minutes (effective 1/1/2018)
PT/OT/ Chiropractic (Physical Medicine)	97010	Application of a modality to one (1) or more areas; hot or cold packs
PT/OT/ Chiropractic (Physical Medicine)	97012	Application of a modality to one (1) or more areas; traction, mechanical
PT/OT/ Chiropractic (Physical Medicine)	97014	Application of a modality to one (1) or more areas; electrical stimulation (unattended)
PT/OT/ Chiropractic (Physical Medicine)	97016	Application of a modality to one (1) or more areas; vasopneumatic devices
PT/OT/ Chiropractic (Physical Medicine)	97018	Application of a modality to one (1) or more areas; paraffin bath
PT/OT/ Chiropractic (Physical Medicine)	97022	Application of a modality to one (1) or more areas; whirlpool
PT/OT/ Chiropractic (Physical Medicine)	97024	Application of a modality to one (1) or more areas; diathermy (e.g., microwave)

PT/OT/ Chiropractic (Physical Medicine)	97026	Application of a modality to one (1) or more areas; infrared
PT/OT/ Chiropractic (Physical Medicine)	97028	Application of a modality to one (1) or more areas; ultraviolet
PT/OT/ Chiropractic (Physical Medicine)	97032	Application of a modality to one (1) or more areas; electrical stimulation (manual), each 15 minutes
PT/OT/ Chiropractic (Physical Medicine)	97033	Application of a modality to one (1) or more areas; iontophoresis, each 15 minutes
PT/OT/ Chiropractic (Physical Medicine)	97034	Application of a modality to one (1) or more areas; contrast baths, each 15 minutes
PT/OT/ Chiropractic (Physical Medicine)	97035	Application of a modality to one (1) or more areas; ultrasound, each 15 minutes
PT/OT/ Chiropractic (Physical Medicine)	97036	Application of a modality to one (1) or more areas; hubbard tank, each 15 minutes
PT/OT/ Chiropractic (Physical Medicine)	97039	Unlisted modality (specify type and time if constant attendance (prior authorization required effective 2/1/2020)
PT/OT/ Chiropractic (Physical Medicine)	97110	Therapeutic procedure, one (1) or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility
PT/OT/ Chiropractic (Physical Medicine)	97112	Therapeutic procedure, one (1) or more areas, each fifteen minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
PT/OT/ Chiropractic (Physical Medicine)	97113	Therapeutic procedure, one (1) or more areas, each 15 minutes; aquatic therapy with therapeutic exercises
PT/OT/ Chiropractic (Physical Medicine)	97116	Therapeutic procedure, one (1) or more areas, each 15 minutes; gait training (includes stair climbing)
PT/OT/ Chiropractic (Physical Medicine)	97124	Therapeutic procedure, one (1) or more areas, each 15 minutes; massage including effleurage, petrissage, and/or tapotement (stroking, compression, percussion)
PT/OT/ Chiropractic (Physical Medicine)	97129	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes (replaces 97127; prior authorization required effective 2/1/2020)
PT/OT/ Chiropractic (Physical Medicine)	97130	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (list separately in addition to code for primary procedure) (replaces 97127; prior authorization required effective 2/1/2020)
PT/OT/ Chiropractic (Physical Medicine)	97139	Unlisted therapeutic procedure (specify) (prior authorization required effective 2/1/2020)
PT/OT/ Chiropractic (Physical Medicine)	97140	Manual therapy techniques, (e.g., mobilization/manipulation, manual lymphatic drainage, traction), one (1) or more regions, each 15 minutes
PT/OT/ Chiropractic (Physical Medicine)	97150	Therapeutic procedure(s), group (two [2] or more individuals)
PT/OT/ Chiropractic (Physical Medicine)	97164	Re-evaluation of physical therapy (prior authorization required effective 2/1/2020)
PT/OT/ Chiropractic (Physical Medicine)	97168	Re-evaluation of occupational therapy (prior authorization required effective 2/1/2020)
PT/OT/ Chiropractic (Physical Medicine)	97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
PT/OT/ Chiropractic (Physical Medicine)	97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by provider, each 15 minutes
PT/OT/ Chiropractic (Physical Medicine)	97535	Self-care/home management training (e.g., activities of daily living [ADL] and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology device/adaptive equipment), direct one-on-one contact by provider, each 15 minutes
PT/OT/ Chiropractic (Physical Medicine)	97537	Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact by provider, each 15 minutes
PT/OT/ Chiropractic (Physical Medicine)	97542	Wheelchair management (e.g., assessment, fitting, training), each 15 minutes
PT/OT/ Chiropractic (Physical Medicine)	97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes
PT/OT/ Chiropractic (Physical Medicine)	97755	Assistive technology assessment (e.g., to restore, augment, or compensate for existing function, optimize functional tasks, and/or maximize environmental accessibility), direct one-on-one contact by provider, with written report, each 15 minutes
PT/OT/ Chiropractic (Physical Medicine)	97799	Unlisted physical medicine/rehabilitation service or procedure (prior authorization required effective 2/1/2020)
PT/OT/ Chiropractic (Physical Medicine)	98925	Osteopathic manipulative treatment (OMT); one (1) to two (2) body regions involved
PT/OT/ Chiropractic (Physical Medicine)	98926	Osteopathic manipulative treatment (OMT); three (3) to four (4) body regions involved
PT/OT/ Chiropractic (Physical Medicine)	98927	Osteopathic manipulative treatment (OMT); five (5) to six (6) body regions involved
PT/OT/ Chiropractic (Physical Medicine)	98928	Osteopathic manipulative treatment (OMT); seven (7) to eight (8) body regions involved
PT/OT/ Chiropractic (Physical Medicine)	98929	Osteopathic manipulative treatment (OMT); nine (9) to ten (10) body regions involved
PT/OT/ Chiropractic (Physical Medicine)	98940	Chiropractic manipulative treatment (CMT); spinal, one (1) to two (2) regions
PT/OT/ Chiropractic (Physical Medicine)	98941	Chiropractic manipulative treatment (CMT); spinal, three (3) to four (4) regions
PT/OT/ Chiropractic (Physical Medicine)	98942	Chiropractic manipulative treatment (CMT); spinal, five (5) regions
PT/OT/ Chiropractic (Physical Medicine)	98943	Chiropractic manipulative treatment (CMT); extraspinal, one (1) or more regions
Radiation Therapy (Radiation Oncology)	0394T	HDR electronic brachytherapy, skin surface application, per fraction
Radiation Therapy (Radiation Oncology)	0395T	HDR electronic brachytherapy, interstitial or intracavitary treatment, per fraction
Radiation Therapy (Radiation Oncology)	77316	Brachytherapy isodose plan; simple (calculation[s] made from 1 to 4 sources, or remote afterloading brachytherapy, 1 channel), includes basic dosimetry calculation(s)
Radiation Therapy (Radiation Oncology)	77317	Brachytherapy isodose plan; intermediate (calculation[s] made from 5 to 10 sources, or remote afterloading brachytherapy, 2-12 channels), includes basic dosimetry calculation(s)
Radiation Therapy (Radiation Oncology)	77318	Brachytherapy isodose plan; complex (calculation[s] made from over 10 sources, or remote afterloading brachytherapy, over 12 channels), includes basic dosimetry calculation(s)
Radiation Therapy (Radiation Oncology)	77750	Infusion or instillation of radioelement solution (includes 3-month follow-up care)
Radiation Therapy (Radiation Oncology)	77761	Intracavitary radiation source application; simple
Radiation Therapy (Radiation Oncology)	77762	Intracavitary radiation source application; intermediate
Radiation Therapy (Radiation Oncology)	77763	Intracavitary radiation source application; complex
Radiation Therapy (Radiation Oncology)	77767	HDR radionuclide skin surface brachytherapy; lesion diameter up to 2.0 cm or 1 channel
Radiation Therapy (Radiation Oncology)	77768	HDR radionuclide skin surface brachytherapy; lesion diameter over 2.0 cm and 2 or more channels, or multiple lesions
Radiation Therapy (Radiation Oncology)	77770	HDR radionuclide interstitial or intracavitary brachytherapy; 1 channel
Radiation Therapy (Radiation Oncology)	77771	HDR radionuclide rate interstitial or intracavitary brachytherapy; 2 to 12 channels

Radiation Therapy (Radiation Oncology)	77772	HDR radionuclide interstitial or intracavitary brachytherapy; over 12 channels
Radiation Therapy (Radiation Oncology)	77778	Interstitial radiation source application, complex, includes supervision, handling, loading of radiation source when performed
Radiation Therapy (Radiation Oncology)	77789	Surface application of low dose rate radionuclide source
Radiation Therapy (Radiation Oncology)	77790	Supervision, handling, loading of radiation source
Radiation Therapy (Radiation Oncology)	77799	Unlisted procedure, clinical brachytherapy (this code to be used in place of 77776 and 77777)
Radiation Therapy (Radiation Oncology)	C2616	Brachytherapy source, nonstranded, yttrium-90, per source
Radiation Therapy (Radiation Oncology)	C9726	Placement and removal (if performed) of applicator into breast for radiation therapy
Radiation Therapy (Radiation Oncology)	G0458	Low dose rate (LDR) prostate brachytherapy services, composite rate
Radiation Therapy (Radiation Oncology)	S2095	Transcatheter occlusion or embolization for tumor destruction, percutaneous, any method, using yttrium-90 microspheres
Radiation Therapy (Radiation Oncology)	77371	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based
Radiation Therapy (Radiation Oncology)	77372	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based
Radiation Therapy (Radiation Oncology)	77373	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions
Radiation Therapy (Radiation Oncology)	77432	Stereotactic radiation treatment management of cranial lesion(s) (complete course of treatment consisting of 1 session)
Radiation Therapy (Radiation Oncology)	77435	Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions
Radiation Therapy (Radiation Oncology)	G0339	Image guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session or first session of fractionated treatment
Radiation Therapy (Radiation Oncology)	G0340	Image guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum 5 sessions per course of treatment
Radiation Therapy (Radiation Oncology)	77301	Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications
Radiation Therapy (Radiation Oncology)	77338	Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan
Radiation Therapy (Radiation Oncology)	77385	Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple
Radiation Therapy (Radiation Oncology)	77386	Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; complex
Radiation Therapy (Radiation Oncology)	G6015	Intensity modulated treatment delivery, single or multiple fields/arcs,via narrow spatially and temporally modulated beams, binary, dynamic mlc, per treatment session
Radiation Therapy (Radiation Oncology)	G6016	Compensator-based beam modulation treatment delivery of inverse planned treatment using 3 or more high resolution (milled or cast) compensator, convergent beam modulated fields, per treatment session
Radiation Therapy (Radiation Oncology)	77423	High energy neutron radiation treatment delivery; 1 or more isocenter(s) with coplanar or non-coplanar geometry with blocking and/or wedge, and/or compensator(s)
Radiation Therapy (Radiation Oncology)	19294	Preparation of tumor cavity, with placement of radiation therapy applicator for intraoperative radiation therapy (IORT), concurrent with partial mastectomy
Radiation Therapy (Radiation Oncology)	77424	Intraoperative radiation treatment delivery, x-ray, single treatment session
Radiation Therapy (Radiation Oncology)	77425	Intraoperative radiation treatment delivery, electrons, single treatment session
Radiation Therapy (Radiation Oncology)	77469	Intraoperative radiation treatment management
Radiation Therapy (Radiation Oncology)	77520	Proton treatment delivery; simple, without compensation
Radiation Therapy (Radiation Oncology)	77522	Proton treatment delivery; simple, with compensation
Radiation Therapy (Radiation Oncology)	77523	Proton treatment delivery; intermediate
Radiation Therapy (Radiation Oncology)	77525	Proton treatment delivery; complex
Radiation Therapy (Radiation Oncology)	S8030	Scleral application of tantalum ring(s) for localization of lesions for proton beam therapy
Radiation Therapy (Radiation Oncology)	77600	Hyperthermia, externally generated; superficial (ie, heating to a depth of 4 cm or less)
Radiation Therapy (Radiation Oncology)	77605	Hyperthermia, externally generated; deep (ie, heating to depths greater than 4 cm)
Radiation Therapy (Radiation Oncology)	77610	Hyperthermia generated by interstitial probe(s); 5 or fewer interstitial applicators
Radiation Therapy (Radiation Oncology)	77615	Hyperthermia generated by interstitial probe(s); more than 5 interstitial applicators
Radiation Therapy (Radiation Oncology)	77620	Hyperthermia generated by intracavitary probe(s)
Radiation Therapy (Radiation Oncology)	77427	Radiation treatment management, 5 treatments
Radiation Therapy (Radiation Oncology)	77431	Radiation therapy management with complete course of therapy consisting of 1 or 2 fractions only
Radiation Therapy (Radiation Oncology)	77470	Special treatment procedure (eg, total body irradiation, hemibody radiation, per oral or endocavitary irradiation)
Radiation Therapy (Radiation Oncology)	77499	Unlisted procedure, therapeutic radiology treatment management
Radiation Therapy (Radiation Oncology)	G6017	Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy (eg, 3d positional tracking, gating, 3d surface tracking), each fraction of treatment
Radiation Therapy (Radiation Oncology)	77261	Therapeutic radiology treatment planning; simple
Radiation Therapy (Radiation Oncology)	77262	Therapeutic radiology treatment planning; intermediate
Radiation Therapy (Radiation Oncology)	77263	Therapeutic radiology treatment planning; complex
Radiation Therapy (Radiation Oncology)	77280	Therapeutic radiology simulation-aided field setting; simple
Radiation Therapy (Radiation Oncology)	77285	Therapeutic radiology simulation-aided field setting; intermediate
Radiation Therapy (Radiation Oncology)	77290	Therapeutic radiology simulation-aided field setting; complex
Radiation Therapy (Radiation Oncology)	77293	Respiratory motion management simulation (List separately in addition to code for primary procedure)
Radiation Therapy (Radiation Oncology)	77299	Unlisted procedure, therapeutic radiology clinical treatment planning
Radiation Therapy (Radiation Oncology)	77401	Radiation treatment delivery, superficial and/or ortho voltage, per day
Radiation Therapy (Radiation Oncology)	77402	Radiation treatment delivery, >1 MeV; simple
Radiation Therapy (Radiation Oncology)	77407	Radiation treatment delivery; two separate treatment areas; three or more ports on a single treatment area; or three or more simple blocks;>=1 MeV; intermediate
Radiation Therapy (Radiation Oncology)	77412	Radiation treatment delivery; three or more separate treatment areas; custom blocking; tangential ports; wedges; rotational beam; field-in-field or other tissue compensation that does not meet IMRT guidelines; or electron beam; >=1 MeV; complex
Radiation Therapy (Radiation Oncology)	77417	Therapeutic radiology port images(s)

Radiation Therapy (Radiation Oncology)	G6003	Radiation treatment delivery, single treatment area,single port or parallel opposed ports, simple blocks or no blocks: up to 5mev
Radiation Therapy (Radiation Oncology)	G6004	Radiation treatment delivery, single treatment area,single port or parallel opposed ports, simple blocks or no blocks: 6-10mev
Radiation Therapy (Radiation Oncology)	G6005	Radiation treatment delivery, single treatment area,single port or parallel opposed ports, simple blocks or no blocks: 11-19mev
Radiation Therapy (Radiation Oncology)	G6006	Radiation treatment delivery, single treatment area,single port or parallel opposed ports, simple blocks or no blocks: 20mev or greater
Radiation Therapy (Radiation Oncology)	G6007	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks: up to 5mev
Radiation Therapy (Radiation Oncology)	G6008	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks: 6-10mev
Radiation Therapy (Radiation Oncology)	G6009	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks: 11-19mev
Radiation Therapy (Radiation Oncology)	G6010	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks: 20 mev or greater
Radiation Therapy (Radiation Oncology)	G6011	Radiation treatment delivery,3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; up to 5mev
Radiation Therapy (Radiation Oncology)	G6012	Radiation treatment delivery,3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 6-10mev
Radiation Therapy (Radiation Oncology)	G6013	Radiation treatment delivery,3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 11-19mev
Radiation Therapy (Radiation Oncology)	G6014	Radiation treatment delivery,3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 20mev or greater
Radiation Therapy (Radiation Oncology)	77014	Computed tomography guidance for placement of radiation therapy fields
Radiation Therapy (Radiation Oncology)	77387	Guidance for localization of target volume for delivery of radiation treatment, includes intrafraction tracking, when performed
Radiation Therapy (Radiation Oncology)	G6001	Ultrasonic guidance for placement of radiation therapy fields
Radiation Therapy (Radiation Oncology)	G6002	Stereoscopic x-ray guidance for localization of target volume for the delivery of radiation therapy
Radiation Therapy (Radiation Oncology)	77295	3-dimensional radiotherapy plan, including dose-volume histograms
Radiation Therapy (Radiation Oncology)	77300	Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, onl
Radiation Therapy (Radiation Oncology)	77306	Teletherapy isodose plan; simple (1 or 2 unmodified ports directed to a single area of interest), includes basic dosimetry calculation(s)
Radiation Therapy (Radiation Oncology)	77307	Teletherapy isodose plan; complex (multiple treatment areas, tangential ports, the use of wedges, blocking, rotational beam, or special beam considerations), includes basic dosimetry calculation(s)
Radiation Therapy (Radiation Oncology)	77321	Special teletherapy port plan, particles, hemibody, total body
Radiation Therapy (Radiation Oncology)	77331	Special dosimetry (eg, TLD, microdosimetry) (specify), only when prescribed by the treating physician
Radiation Therapy (Radiation Oncology)	77332	Treatment devices, design and construction; simple (simple block, simple bolus)
Radiation Therapy (Radiation Oncology)	77333	Treatment devices, design and construction; intermediate (multiple blocks, stents, bite blocks, special bolus)
Radiation Therapy (Radiation Oncology)	77334	Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)
Radiation Therapy (Radiation Oncology)	77336	Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy
Radiation Therapy (Radiation Oncology)	77370	Special medical radiation physics consultation
Radiation Therapy (Radiation Oncology)	77399	Unlisted procedure, medical radiation physics, dosimetry and treatment devices, and special services
Radiation Therapy (Radiation Oncology)	79005	Radiopharmaceutical therapy, by oral administration; used for I-131 treatment
Radiation Therapy (Radiation Oncology)	79101	Radiopharmaceutical, therapy, by intravenous administration
Radiation Therapy (Radiation Oncology)	79403	Radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion
Radiation Therapy (Radiation Oncology)	A9513	Lutetium Lu 177, dotatate, therapeutic, 1 mCi
Radiation Therapy (Radiation Oncology)	A9543	Yttrium 90 Ibritumomab Tiuxetan (Zevalin)
Radiation Therapy (Radiation Oncology)	A9606	Radium RA-223 dichloride, therapeutic, per microcurie (Xofigo)
Radiation Therapy (Radiation Oncology)	A9590	Iodine i-131, iobenguane, 1 millicurie
Radiation Therapy (Radiation Oncology)	A9699	Radiopharmaceutical, therapeutic, not otherwise classified
Radiation Therapy (Radiation Oncology)	19296	Placement of radiotherapy afterloading expandable catheter (single or multichannel) into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy
Radiation Therapy (Radiation Oncology)	19297	Placement of radiotherapy afterloading expandable catheter (single or multichannel) into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; concurrent with partial mastectomy (List separately in addition to code for primary procedure)
Radiation Therapy (Radiation Oncology)	19298	Placement of radiotherapy after loading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes imaging guidance
Radiation Therapy (Radiation Oncology)	31643	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of catheter(s) for intracavitary radioelement application
Radiation Therapy (Radiation Oncology)	32553	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-thoracic, single or multiple
Radiation Therapy (Radiation Oncology)	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
Radiation Therapy (Radiation Oncology)	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
Radiation Therapy (Radiation Oncology)	49412	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), open, intra-abdominal, intrapelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple (List separately in addition to code for primary procedure)
Radiation Therapy (Radiation Oncology)	55875	Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy

Radiation Therapy (Radiation Oncology)	55876	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple
Radiation Therapy (Radiation Oncology)	55920	Placement of needles or catheters into pelvic organs and/or genitalia (except prostate) for subsequent interstitial radioelement application
Radiation Therapy (Radiation Oncology)	57155	Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy
Radiation Therapy (Radiation Oncology)	57156	Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy
Radiation Therapy (Radiation Oncology)	58346	Insertion of Heyman capsules for clinical brachytherapy
Radiation Therapy (Radiation Oncology)	76873	Ultrasound, transrectal; prostate volume study for brachytherapy treatment planning (separate procedure)
Radiation Therapy (Radiation Oncology)	76965	Ultrasonic guidance for interstitial radioelement application
Radiation Therapy (Radiation Oncology)	61796	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 simple cranial lesion
Radiation Therapy (Radiation Oncology)	61797	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, simple (List separately in addition to code for primary procedure)
Radiation Therapy (Radiation Oncology)	61798	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 complex cranial lesion
Radiation Therapy (Radiation Oncology)	61799	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, complex (List separately in addition to code for primary procedure)
Radiation Therapy (Radiation Oncology)	61800	Application of stereotactic headframe for stereotactic radiosurgery (List separately in addition to code for primary procedure)
Reconstructive /Possibly Cosmetic	11960	INSERTION OF TISSUE EXPANDER(S) FOR OTHER THAN BREAST, INCLUDING SUBSEQUENT EXPANSION
Reconstructive /Possibly Cosmetic	15775	PUNCH GRAFT FOR HAIR TRANSPLANT; 1 TO 15 PUNCH GRAFTS
Reconstructive /Possibly Cosmetic	15776	PUNCH GRAFT FOR HAIR TRANSPLANT; MORE THAN 15 PUNCH GRAFTS
Reconstructive /Possibly Cosmetic	15780	DERMABRASION; TOTAL FACE (EG, FOR ACNE SCARRING, FINE WRINKLING, RHYTIDS, GENERAL KERATOSIS)
Reconstructive /Possibly Cosmetic	15781	DERMABRASION; SEGMENTAL, FACE
Reconstructive /Possibly Cosmetic	15782	DERMABRASION REGIONAL, OTHER THAN FACE
Reconstructive /Possibly Cosmetic	15783	DERMABRASION; SUPERFICIAL, ANY SITE (EG, TATTOO REMOVAL)
Reconstructive /Possibly Cosmetic	15786	ABRASION; SINGLE LESION (EG, KERATOSIS, SCAR)
Reconstructive /Possibly Cosmetic	15787	ABRASION; EACH ADDITIONAL 4 LESIONS OR LESS (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
Reconstructive /Possibly Cosmetic	15788	CHEMICAL PEEL, FACIAL; EPIDERMAL
Reconstructive /Possibly Cosmetic	15789	CHEMICAL PEEL, FACIAL; DERMAL
Reconstructive /Possibly Cosmetic	15792	CHEMICAL PEEL, NONFACIAL; EPIDERMAL
Reconstructive /Possibly Cosmetic	15793	CHEMICAL PEEL, NONFACIAL; DERMAL
Reconstructive /Possibly Cosmetic	15819	CERVICOPLASTY
Reconstructive /Possibly Cosmetic	15820	BLEPHAROPLASTY, LOWER EYELID;
Reconstructive /Possibly Cosmetic	15821	BLEPHAROPLASTY, LOWER EYELID; WITH EXTENSIVE HERNIATED FAT PAD
Reconstructive /Possibly Cosmetic	15822	BLEPHAROPLASTY, UPPER EYELID;
Reconstructive /Possibly Cosmetic	15823	BLEPHAROPLASTY, UPPER EYELID; WITH EXTENSIVE SKIN WEIGHTING DOWN LID
Reconstructive /Possibly Cosmetic	15824	RHYTIDECTOMY; FOREHEAD
Reconstructive /Possibly Cosmetic	15825	RHYTIDECTOMY; NECK WITH PLATYSMAL TIGHTENING (PLATYSMAL FLAP, P-FLAP)
Reconstructive /Possibly Cosmetic	15826	RHYTIDECTOMY; GLABELLAR FROWN LINES
Reconstructive /Possibly Cosmetic	15828	RHYTIDECTOMY; CHEEK, CHIN, AND NECK
Reconstructive /Possibly Cosmetic	15829	RHYTIDECTOMY; SUPERFICIAL MUSCULOAPONEUROTIC SYSTEM (SMAS) FLAP
Reconstructive /Possibly Cosmetic	15830	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY); ABDOMEN, INFRAUMBILICAL PANNICULECTOMY
Reconstructive /Possibly Cosmetic	15832	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY; THIGH
Reconstructive /Possibly Cosmetic	15833	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY; LEG
Reconstructive /Possibly Cosmetic	15834	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY; HIPS
Reconstructive /Possibly Cosmetic	15835	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY; BUTTOCK
Reconstructive /Possibly Cosmetic	15836	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY; ARM
Reconstructive /Possibly Cosmetic	15837	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY; FOREARM OR HAND
Reconstructive /Possibly Cosmetic	15838	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); SUBMENTAL FAT PAD
Reconstructive /Possibly Cosmetic	15839	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); OTHER AREAS
Reconstructive /Possibly Cosmetic	15847	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY), ABDOMEN (EG, ABDOMINOPLASTY) (INCLUDES UMBILICAL TRANSPOSITION AND FASCIAL PLICATION) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
Reconstructive /Possibly Cosmetic	15876	SUCTION ASSISTED LIPECTOMY; HEAD AND NECK
Reconstructive /Possibly Cosmetic	15877	SUCTION ASSISTED LIPECTOMY; TRUNK
Reconstructive /Possibly Cosmetic	15878	SUCTION ASSISTED LIPECTOMY; UPPER EXTREMITY
Reconstructive /Possibly Cosmetic	15879	SUCTION ASSISTED LIPECTOMY; LOWER EXTREMITY
Reconstructive /Possibly Cosmetic	17106	DESTRUCTION OF CUTANEOUS VASCULAR PROLIFERATIVE LESIONS (EG, LASER TECHNIQUE); LESS THAN 10 SQ CM
Reconstructive /Possibly Cosmetic	17107	DESTRUCTION OF CUTANEOUS VASCULAR PROLIFERATIVE LESIONS (EG, LASER TECHNIQUE); 10.0 - 50 SQ CM
Reconstructive /Possibly Cosmetic	17108	DESTRUCTION OF CUTANEOUS VASCULAR PROLIFERATIVE LESIONS (EG, LASER TECHNIQUE); OVER 50 SQ CM
Reconstructive /Possibly Cosmetic	17999	UNLISTED PROCEDURE, SKIN, MUCOUS MEMBRANE AND SUBCUTANEOUS TISSUE
Reconstructive /Possibly Cosmetic	19318	REDUCTION MAMMOPLASTY
Reconstructive /Possibly Cosmetic	19324	MAMMOPLASTY, AUGMENTATION; WITHOUT PROSTHETIC IMPLANT
Reconstructive /Possibly Cosmetic	19325	MAMMOPLASTY, AUGMENTATION; WITH PROSTHETIC IMPLANT
Reconstructive /Possibly Cosmetic	19355	CORRECTION OF INVERTED NIPPLES
Reconstructive /Possibly Cosmetic	19396	PREPARATION OF MOULAGE FOR CUSTOM BREAST IMPLANT
NOC Other	NOC**	OLIPUDASE ALFA (XENPOZYME)
Site of Care	J0129	INJECTION, ABATACEPT, 10 MG (ORENCIA)
Site of Care	J0180	INJECTION, AGALSIDASE BETA, 1 MG (FABRAZYME)
Site of Care	J0219	INJECTION, AVALGLUCOSIDASE ALFA-NGPT, 4 MG (NEXVIAZYME)

**Select new-to-market drugs with not otherwise classified (NOC) HCPCS codes (e.g. J3490, J3590, J9999, C9399) will require prior authorization, pending unique HCPCS assignment by CMS

Site of Care	J0221	INJECTION ALGLUCOSIDASE ALFA, (LUMIZYME), 10 MG
Site of Care	J0222	INJECTION, PATISIRAN, 0.1 MG (ONPATTRO)
NOC Other	NOC**	PEGFILGRASTIM-FPGK (STIMUFEND)
NOC Other	NOC**	SPESOLIMAB-SBZO (SPEVIGO)
NOC Other	NOC**	VUTRISIRAN (AMVUTTRA)
Site of Care	J0257	INJECTION, ALPHA 1 PROTEINASE INHIBITOR (HUMAN) 10 MG (GLASSIA)
Site of Care	J0490	INJECTION, BELIMUMAB, 10 MG (BENLYSTA)
Site of Care	J0491	INJECTION, ANIFROLUMAB-FNIA, 1 MG (SAPHNELO)
Site of Care	J0596	INJECTION, C1 ESTERASE INHIBITOR (RECOMBINANT), RUCONEST, 10 UNITS
Site of Care	J0597	INJECTION, C1 ESTERASE INHIBITOR (HUMAN), BERINERT, 10 UNITS
Site of Care	J0598	INJECTION, C-1 ESTERASE INHIBITOR (HUMAN), CINRYZE, 10 UNITS
Site of Care	J0791	INJECTION, CRIZANLIZUMAB-TMCA, 5 MG (ADAKVEO)
Site of Care	J1300	INJECTION, ECULIZUMAB, 10 MG (SOLIRIS)
Site of Care	J1301	INJECTION, EDARAVONE, 1 MG (RADICAVA)
Site of Care	J1303	INJECTION, RAVULIZUMAB-CWVZ, 10 MG (ULTOMIRIS)
Site of Care	J1305	INJECTION, EVINACUMAB-DGNB, 5 MG (EVKEEZA)
Site of Care	J1322	INJECTION, ELOSULFASE ALFA, 1 MG (VIMIZIM)
Site of Care	J1458	INJECTION, GALSULFASE, 1 MG (NAGLAZYME)
Site of Care	J1459	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, NON-LYOPHILIZED (E.G.LIQUID), 500 MG (PRIVIGEN)
Site of Care	J1554	INJECTION, IMMUNE GLOBULIN (ASCENIV), 500 MG
Site of Care	J1556	INJECTION, IMMUNE GLOBULIN (BIVIGAM), 500 MG
Site of Care	J1557	INJECTION, IMMUNE GLOBULIN, (GAMMAPLEX), INTRAVENOUS, NON-LYOPHILIZED (E.G.LIQUID), 500 MG
Site of Care	J1561	INJECTION, IMMUNE GLOBULIN, (GAMUNEX-C/GAMMAKED), NON-LYOPHILIZED (E.G. LIQUID), 500 MG
NOC Other	NOC**	SUTIMLIMAB-JOME (ENJAYMO)
NOC Other	NOC**	BETIBEGLOGENE AUTOTEMCEL (ZYNTEGLO)
Site of Care	J1568	INJECTION, IMMUNE GLOBULIN, (OCTAGAM), INTRAVENOUS, NON-LYOPHILIZED (E.G., LIQUID), 500 MG
Site of Care	J1569	INJECTION, IMMUNE GLOBULIN, (GAMMAGARD LIQUID), NON-LYOPHILIZED, (E.G. LIQUID), 500MG
Site of Care	J1572	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, (FLEBOGAMMA/FLEBOGAMMA DIF), INTRAVENOUS, NON- LYOPHILIZED (E.G. LIQUID), 500 MG
Site of Care	J1599	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, NON-LYOPHILIZED (E.G. LIQUID), NOT OTHERWISE SPECIFIED, 500 MG
Site of Care	J1602	INJECTION, GOLIMUMAB, 1 MG, FOR INTRAVENOUS USE (SIMPONI ARIA)
Site of Care	J1743	INJECTION, IDURSULFASE, 1 MG (ELAPRASE)
Site of Care	J1745	INJECTION INFLIXIMAB, 10 MG (REMICADE)
Site of Care	J1786	INJECTION, IMIGLUCERASE, 10 UNITS (CEREZYME)
Site of Care	J1823	INJECTION, INEBILIZUMAB-CDON, 1MG (UPLIZNA)
Site of Care	J1931	INJECTION, LARONIDASE, 0.1 MG (ALDURAZYME)
Site of Care	J2350	INJECTION, OCRELIZUMAB, 1 MG (OCREVUS)
Site of Care	J2840	INJECTION, SEBELIPASE ALFA, 1 MG (KANUMA)
Site of Care	J3032	INJECTION, EPTINEZUMAB-JJMR, 1MG (VYEPTI)
Site of Care	J3060	INJECTION, TALIGLUCERACE ALFA, 10 UNITS (ELELYSO)
Site of Care	J3241	INJECTION, TEPROTUMUMAB-TRBW, 10 MG (TEPEZZA)
Site of Care	J3262	INJECTION, TOCILIZUMAB, 1 MG (ACTEMRA)
Site of Care	J3380	INJECTION, VEDOLIZUMAB, 1 MG (ENTYVIO)
Site of Care	J3385	INJECTION, VELAGLUCERASE ALFA, 100 UNITS (VPRIV)
Site of Care	J3397	INJECTION, VESTRONIDASE ALFA-VJBK, 1 MG (MEPSEVII)
Site of Care	J9332	INJECTION, EFGARTIGIMOD ALFA-FCAB, 2MG (VYVGART)
Site of Care	Q5103	INJECTION, INFLIXIMAB-DYYB, BIOSIMILAR, (INFLECTRA), 10 MG
Site of Care	Q5104	INJECTION, INFLIXIMAB-ABDA, BIOSIMILAR, (RENFLEXIS), 10 MG
Site of Care	Q5121	INJECTION, INFLIXIMAB-AXXQ, BIOSIMILAR, (AVSOLA), 10 MG
Specialty Surgeries	43644	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; WITH GASTRIC BYPASS AND ROUX-EN-Y GASTROENTEROSTOMY (ROUX LIMB 150 CM OR LESS)
Specialty Surgeries	43645	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; WITH GASTRIC BYPASS AND SMALL INTESTINE RECONSTRUCTION TO LIMIT ABSORPTION
Specialty Surgeries	43647	LAPAROSCOPY, SURGICAL; IMPLANTATION OR REPLACEMENT OF GASTRIC NEUROSTIMULATOR ELECTRODES, ANTRUM
Specialty Surgeries	43659	UNLISTED LAPAROSCOPY PROCEDURE, STOMACH
Specialty Surgeries	43770	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; PLACEMENT OF ADJUSTABLE GASTRIC RESTRICTIVE DEVICE (E.G., GASTRIC BAND AND SUBCUTANEOUS PORT COMPONENTS)
Specialty Surgeries	43771	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; REVISION OF ADJUSTABLE GASTRIC RESTRICTIVE DEVICE COMPONENT ONLY
Specialty Surgeries	43772	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; REMOVAL OF ADJUSTABLE GASTRIC RESTRICTIVE DEVICE COMPONENT ONLY
Specialty Surgeries	43773	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; REMOVAL AND REPLACEMENT OF ADJUSTABLE GASTRIC RESTRICTIVE DEVICE COMPONENT ONLY
Specialty Surgeries	43774	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; REMOVAL OF ADJUSTABLE GASTRIC RESTRICTIVE DEVICE AND SUBCUTANEOUS PORT COMPONENTS
Specialty Surgeries	43775	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; LONGITUDINAL GASTRECTOMY (IE, SLEEVE GASTRECTOMY)
Specialty Surgeries	43842	GASTRIC RESTRICTIVE PROCEDURE, WITHOUT GASTRIC BYPASS, FOR MORBID OBESITY; VERTICAL-BANDED GASTROPLASTY
Specialty Surgeries	43843	GASTRIC RESTRICTIVE PROCEDURE, WITHOUT GASTRIC BYPASS, FOR MORBID OBESITY; OTHER THAN VERTICAL-BANDED GASTROPLASTY

Specialty Surgeries	43845	GASTRIC RESTRICTIVE PROCEDURE WITH PARTIAL GASTRECTOMY, PYLORUS-PRESERVING DUODENOILEOSTOMY AND ILEOILEOSTOMY (50 TO 100 CM COMMON CHANNEL) TO LIMIT ABSORPTION (BILIOPANCREATIC DIVERSION WITH DUODENAL SWITCH)
Specialty Surgeries	43846	GASTRIC RESTRICTIVE PROCEDURE, WITH GASTRIC BYPASS FOR MORBID OBESITY; WITH SHORT LIMB (150 CM OR LESS) ROUX-EN-Y GASTROENTEROSTOMY
Specialty Surgeries	43847	GASTRIC RESTRICTIVE PROCEDURE, WITH GASTRIC BYPASS FOR MORBID OBESITY; WITH SMALL INTESTINE RECONSTRUCTION TO LIMIT ABSORPTION
Specialty Surgeries	43848	REVISION, OPEN, OF GASTRIC RESTRICTIVE PROCEDURE FOR MORBID OBESITY, OTHER THAN ADJUSTABLE GASTRIC RESTRICTIVE DEVICE (SEPARATE PROCEDURE)
Specialty Surgeries	43881	IMPLANTATION OR REPLACEMENT OF GASTRIC NEUROSTIMULATOR ELECTRODES, ANTRUM, OPEN
Specialty Surgeries	43886	GASTRIC RESTRICTIVE PROCEDURE, OPEN; REVISION OF SUBCUTANEOUS PORT COMPONENT ONLY
Specialty Surgeries	43887	GASTRIC RESTRICTIVE PROCEDURE, OPEN; REMOVAL OF SUBCUTANEOUS PORT COMPONENT ONLY
Specialty Surgeries	43888	GASTRIC RESTRICTIVE PROCEDURE, OPEN; REMOVAL AND REPLACEMENT OF SUBCUTANEOUS PORT COMPONENT ONLY
Specialty Surgeries	43999	UNLISTED PROCEDURE, STOMACH
NOC Other	NOC**	PARATHYROID HORMONE (NATPARA)
Surgery (Musculoskeletal)	20930	Allograft, morselized, or placement of osteopromotive material, for spine surgery only (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	20931	Allograft, structural, for spine surgery only (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	20936	Autograft for spine surgery only (includes harvesting the graft); local (e.g., ribs, spinous process, or laminar fragments) obtained from same incision (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	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)
Surgery (Musculoskeletal)	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)
Surgery (Musculoskeletal)	20974	Electrical stimulation to aid bone healing; noninvasive (nonoperative)
Surgery (Musculoskeletal)	20975	Electrical stimulation to aid bone healing; invasive (operative)
Surgery (Musculoskeletal)	22214	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumbar
Surgery (Musculoskeletal)	22510	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic
Surgery (Musculoskeletal)	22511	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral
Surgery (Musculoskeletal)	22512	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	22513	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic
Surgery (Musculoskeletal)	22514	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar
Surgery (Musculoskeletal)	22515	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed)
Surgery (Musculoskeletal)	22532	Lateral Extracavitary Approach Technique ArthrodesisProcedures on the Spine (Vertebral Column).
Surgery (Musculoskeletal)	22533	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar
Surgery (Musculoskeletal)	22534	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic or lumbar, each additional vertebral segment (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2
Surgery (Musculoskeletal)	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)
Surgery (Musculoskeletal)	22554	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2
Surgery (Musculoskeletal)	22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar
Surgery (Musculoskeletal)	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)
Surgery (Musculoskeletal)	22600	Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment
Surgery (Musculoskeletal)	22612	Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)
Surgery (Musculoskeletal)	22614	Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar
Surgery (Musculoskeletal)	22632	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	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

Surgery (Musculoskeletal)	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)
Surgery (Musculoskeletal)	22830	Exploration of spinal fusion
Surgery (Musculoskeletal)	22840	Posterior non-segmental instrumentation (eg, 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)
Surgery (Musculoskeletal)	22841	Internal spinal fixation by wiring of spinous processes (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	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)
Surgery (Musculoskeletal)	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)
Surgery (Musculoskeletal)	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)
Surgery (Musculoskeletal)	22845	Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	22846	Anterior instrumentation; 4 to 7 vertebral segments (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	22847	Anterior instrumentation; 8 or more vertebral segments (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	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)
Surgery (Musculoskeletal)	22852	Removal of posterior segmental instrumentation
Surgery (Musculoskeletal)	22853	Insertion of interbody biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (List separately in addition to code for primary procedure
Surgery (Musculoskeletal)	22854	Insertion of intervertebral biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	22855	Removal of anterior instrumentation
Surgery (Musculoskeletal)	22856	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); single interspace, cervical
Surgery (Musculoskeletal)	22857	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar
Surgery (Musculoskeletal)	22858	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); second level, cervical (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	22859	Insertion of intervertebral biomechanical device(s) (e.g., synthetic cage, mesh, methylmethacrylate) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	22861	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical
Surgery (Musculoskeletal)	22862	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar
Surgery (Musculoskeletal)	22867	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level
Surgery (Musculoskeletal)	22868	Insertion Of Interlaminar/Interspinous Process Stabilization/Distraction Device, Without Fusion, Including Image Guidance When Performed, With Open Decompression, Lumbar; Second Level (List Separately In Addition To Code For Primary Procedure)
Surgery (Musculoskeletal)	22869	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level
Surgery (Musculoskeletal)	22870	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)
NOC Other	NOC**	PEGCETACOPLAN (EMPAVELI)
Surgery (Musculoskeletal)	62380	Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar
Surgery (Musculoskeletal)	63001	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), 1 or 2 vertebral segments; cervical
Surgery (Musculoskeletal)	63005	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy
Surgery (Musculoskeletal)	63012	Laminectomy with removal of abnormal facets and/or pars inter- articularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure)
Surgery (Musculoskeletal)	63015	Laminectomy with exploration and/or decompression of spinal
Surgery (Musculoskeletal)	63017	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), more than 2 vertebral segments; lumbar
Surgery (Musculoskeletal)	63020	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical
Surgery (Musculoskeletal)	63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar

Surgery (Musculoskeletal)	63035	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	63040	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; cervical
Surgery (Musculoskeletal)	63042	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar
Surgery (Musculoskeletal)	63043	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional cervical interspace (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	63044	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional lumbar interspace (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	63045	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis]), single vertebral segment; cervical
Surgery (Musculoskeletal)	63047	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis]), single vertebral segment; lumbar
Surgery (Musculoskeletal)	63048	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	63050	Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments;
Surgery (Musculoskeletal)	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 [e.g., wire, suture, mini- plates], when performed)
Surgery (Musculoskeletal)	63056	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (e.g., herniated intervertebral disc), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (e.g., far lateral herniated intervertebral disc)
Surgery (Musculoskeletal)	63057	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (e.g., herniated intervertebral disc), single segment; each additional segment, thoracic or lumbar (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	63075	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace
Surgery (Musculoskeletal)	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)
Surgery (Musculoskeletal)	63081	Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment
Surgery (Musculoskeletal)	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)
Surgery (Musculoskeletal)	0095T	Removal of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	0098T	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	0163T	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), each additional interspace, lumbar (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	0164T	Removal of total disc arthroplasty, (artificial disc), anterior approach, each additional interspace, lumbar (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	0165T	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, lumbar (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	0274T	Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (e.g., fluoroscopic, CT), single or multiple levels, unilateral or bilateral; cervical or thoracic
Surgery (Musculoskeletal)	0275T	Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (e.g., fluoroscopic, CT), single or multiple levels, unilateral or bilateral; lumbar
Surgery (Musculoskeletal)	C9757	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and excision of herniated intervertebral disc, and repair of annular defect with implantation of bone anchored annular closure device, including annular defect measurement, alignment and sizing assessment, and image guidance; 1 interspace, lumbar
Surgery (Musculoskeletal)	E0748	Osteogenesis stimulator, electrical, noninvasive, spinal applications
Surgery (Musculoskeletal)	E0749	Osteogenesis stimulator, electrical, surgically implanted
Transplant	32851	LUNG TRANSPLANT, SINGLE; WITHOUT CARDIOPULMONARY BYPASS
Transplant	32852	LUNG TRANSPLANT, SINGLE; WITH CARDIOPULMONARY BYPASS
Transplant	32853	LUNG TRANSPLANT, DOUBLE (BILATERAL DEQUENTIAL OR EN BLOC); WITHOUT CARDIOPULMONARY BYPASS
Transplant	32854	LUNG TRANSPLANT, DOUBLE (BILATERAL DEQUENTIAL OR EN BLOC); WITH CARDIOPULMONARY BYPASS
NOC Other	NOC**	CASIMERSEN (AMONDYS 45)
Transplant	38243	HEMATOPOIETIC PROGENITOR CELL (HPC); HPC BOOST
Transplant	33935	HEART-LUNG TRANSPLANT WITH RECIPIENT CARDIECTOMY-PNEUMONECTOMY
Transplant	33945	HEART TRANSPLANT, WITH OR WITHOUT RECIPIENT CARDIECTOMY
Transplant	38240	HEMATOPOIETIC PROGENITOR CELL (HPC); ALLOGENEIC TRANSPLANTATION PER DONOR
Transplant	38241	HEMATOPOIETIC PROGENITOR CELL (HPC); AUTOLOGOUS TRANSPLANTATION

NOC Other	NOC**	PEGINTERFERON BETA-1A (PLEGRIDY)
Transplant	44135	INTESTINAL ALLOTRANSPLANTATION; FROM CADAVER DONOR
Transplant	44136	INTESTINAL ALLOTRANSPLANTATION; FROM LIVING DONOR
Transplant	47135	LIVER ALLOTRANSPLANTATION; ORTHOTOPIC, PARTIAL OR WHOLE, FROM CADAVER OR LIVING DONOR, ANY AGE
Transplant	48554	TRANSPLANTATION OF PANCREATIC ALLOGRAFT
Transplant	50360	RENAL ALLOTRANSPLANTATION, IMPLANTATION OF GRAFT; WITHOUT RECIPIENT NEPHRECTOMY
Transplant	50365	RENAL ALLOTRANSPLANTATION, IMPLANTATION OF GRAFT; WITH RECIPIENT NEPHRECTOMY
Transplant	S2053	TRANSPLANTATION OF SMALL INTESTINE AND LIVER ALLOGRAFTS
Transplant	S2054	TRANSPLANTATION OF MULTIVISCERAL ORGANS
Transplant	S2060	LOBAR LUNG TRANSPLANTATION
Transplant	S2065	SIMULTANEOUS PANCREAS KIDNEY TRANSPLANTATION

Exhibit 3
Highmark Prior Authorization List
Part B Drugs at Point of Sale (Pharmacy)
(Effective 10/1/22)

Label Name	Drug Category
CYRAMZA 100 MG/10 ML VIAL	Infusion Pump
CYRAMZA 500 MG/50 ML VIAL	Infusion Pump
PORTRAZZA 800 MG/50 ML VIAL	Infusion Pump
NULOJIX 250 MG VIAL	Immunosuppressant
EMPLICITI 300 MG VIAL	Infusion Pump
EMPLICITI 400 MG VIAL	Infusion Pump
CELLCEPT 250 MG CAPSULE	Immunosuppressant
CELLCEPT 500 MG TABLET	Immunosuppressant
CELLCEPT 200 MG/ML ORAL SUSP	Immunosuppressant
CELLCEPT 500 MG VIAL	Immunosuppressant
CYTOVENE 500 MG VIAL	Infusion Pump
EMEND 80 MG CAPSULE	Antiemetic for CINV
EMEND 125 MG CAPSULE	Antiemetic for CINV
EMEND 40 MG CAPSULE	Antiemetic for CINV
EMEND 125 MG POWDER PACKET	Antiemetic for CINV
EMEND TRIPACK	Antiemetic for CINV
RECOMBIVAX HB 5 MCG/0.5 ML SYR	Hepatitis B vaccine
RECOMBIVAX HB 10 MCG/ML SYR	Hepatitis B vaccine
RECOMBIVAX HB 5 MCG/0.5 ML VL	Hepatitis B vaccine
RECOMBIVAX HB 40 MCG/ML VIAL	Hepatitis B vaccine
RECOMBIVAX HB 10 MCG/ML VIAL	Hepatitis B vaccine
RAPAMUNE 1 MG/ML ORAL SOLN	Immunosuppressant
RAPAMUNE 0.5 MG TABLET	Immunosuppressant
RAPAMUNE 1 MG TABLET	Immunosuppressant
RAPAMUNE 2 MG TABLET	Immunosuppressant
MEDROL 2 MG TABLET	Immunosuppressant
MEDROL 8 MG TABLET	Immunosuppressant
MEDROL 4 MG TABLET	Immunosuppressant
MEDROL 16 MG TABLET	Immunosuppressant
MEDROL 32 MG TABLET	Immunosuppressant
ATGAM 50 MG/ML AMPUL	Immunosuppressant
CESAMET 1 MG CAPSULE	Antiemetic for CINV
MARINOL 2.5 MG CAPSULE	Antiemetic for CINV
MARINOL 5 MG CAPSULE	Antiemetic for CINV
MARINOL 10 MG CAPSULE	Antiemetic for CINV
ONDANSETRON 4 MG/5 ML SOLUTION	Antiemetic for CINV
GRANISETRON HCL 1 MG TABLET	Antiemetic for CINV
MYCOPHENOLATE 250 MG CAPSULE	Immunosuppressant
MYCOPHENOLATE 500 MG TABLET	Immunosuppressant
CYCLOPHOSPHAMIDE 25 MG CAPSUL	Oral Chemo
CYCLOPHOSPHAMIDE 50 MG CAPSUL	Oral Chemo

EVEROLIMUS 0.25 MG TABLET	Immunosuppressant
EVEROLIMUS 0.5 MG TABLET	Immunosuppressant
EVEROLIMUS 0.75 MG TABLET	Immunosuppressant
EVEROLIMUS 1 MG TABLET	Immunosuppressant
METHOTREXATE 2.5 MG TABLET	Oral Chemo
DUOPA 4.63 MG-20 MG/ML SUSPENS	Infusion Pump
GENGRAF 25 MG CAPSULE	Immunosuppressant
GENGRAF 100 MG CAPSULE	Immunosuppressant
GENGRAF 100 MG/ML SOLUTION	Immunosuppressant
SANDIMMUNE 50 MG/ML AMPUL	Immunosuppressant
SANDIMMUNE 100 MG/ML SOLN	Immunosuppressant
SANDIMMUNE 25 MG CAPSULE	Immunosuppressant
SANDIMMUNE 100 MG CAPSULE	Immunosuppressant
NEORAL 25 MG GELATIN CAPSULE	Immunosuppressant
NEORAL 100 MG GELATIN CAPSULE	Immunosuppressant
NEORAL 100 MG/ML SOLUTION	Immunosuppressant
SIMULECT 20 MG VIAL	Immunosuppressant
MYFORTIC 180 MG TABLET	Immunosuppressant
MYFORTIC 360 MG TABLET	Immunosuppressant
SIMULECT 10 MG VIAL	Immunosuppressant
ZORTRESS 0.5 MG TABLET	Immunosuppressant
ZORTRESS 0.75 MG TABLET	Immunosuppressant
ZORTRESS 0.25 MG TABLET	Immunosuppressant
ZORTRESS 1 MG TABLET	Immunosuppressant
TOBI 300 MG/5 ML SOLUTION	Nebulizer
ARZERRA 100 MG/5 ML VIAL	Infusion Pump
ZOFRAN 4 MG TABLET	Antiemetic for CINV
ZOFRAN 8 MG TABLET	Antiemetic for CINV
ARZERRA 1,000 MG/50 ML VIAL	Infusion Pump
TOBRAMYCIN 300 MG/4 ML AMPULE	Nebulizer
FORMOTEROL 20 MCG/2 ML NEB VL	Nebulizer
TOBRAMYCIN 300 MG/5 ML AMPULE	Nebulizer
LEVALBUTEROL 0.31 MG/3 ML SOL	Nebulizer
LEVALBUTEROL 0.63 MG/3 ML SOL	Nebulizer
LEVALBUTEROL CONC 1.25 MG/0.5	Nebulizer
LEVALBUTEROL 1.25 MG/3 ML SOL	Nebulizer
CYCLOSPORINE MODIFIED 25 MG	Immunosuppressant
CYCLOSPORINE MODIFIED 50 MG	Immunosuppressant
CYCLOSPORINE MODIFIED 100 MG	Immunosuppressant
ARFORMOTEROL 15 MCG/2 ML SOLN	Nebulizer
BUDESONIDE 0.25 MG/2 ML SUSP	Nebulizer
BUDESONIDE 0.5 MG/2 ML SUSP	Nebulizer
BUDESONIDE 1 MG/2 ML INH SUSP	Nebulizer
MYCOPHENOLIC ACID DR 180 MG TB	Immunosuppressant
MYCOPHENOLIC ACID DR 360 MG TB	Immunosuppressant
BLEOMYCIN SULFATE 15 UNIT VIAL	Infusion Pump
BLEOMYCIN SULFATE 30 UNIT VIAL	Infusion Pump
DOPAMINE 200 MG/5 ML VIAL	Infusion Pump

DOPAMINE 400 MG/10 ML VIAL	Infusion Pump
FLOXURIDINE 500 MG VIAL	Infusion Pump
GANCICLOVIR 500 MG VIAL	Infusion Pump
MILRINONE LACT 20 MG/20 ML VL	Infusion Pump
MILRINONE LACT 10 MG/10 ML VL	Infusion Pump
METHOTREXATE 50 MG/2 ML VIAL	Oral Chemo
AZATHIOPRINE SOD 100 MG VIAL	Immunosuppressant
MILRINONE LACT 50 MG/50 ML VL	Infusion Pump
MILRINONE-D5W 40 MG/200 ML	Infusion Pump
MILRINONE-D5W 20 MG/100 ML	Infusion Pump
CLADRIBINE 10 MG/10 ML VIAL	Infusion Pump
AMIODARONE 150 MG/3 ML VIAL	Infusion Pump
CROMOLYN 20 MG/2 ML NEB SOLN	Nebulizer
CYCLOSPORINE MODIFIED 100MG/ML	Immunosuppressant
ZOFRAN 4 MG/5 ML ORAL SOLN	Antiemetic for CINV
FLOLAN 0.5 MG VIAL	Infusion Pump
FLOLAN 1.5 MG VIAL	Infusion Pump
PULMICORT 0.25 MG/2 ML RESPUL	Nebulizer
PULMICORT 0.5 MG/2 ML RESPULE	Nebulizer
PULMICORT 1 MG/2 ML RESPULE	Nebulizer
NITROPRESS 50 MG/2 ML VIAL	Infusion Pump
DOPAMINE 200 MG-D5W 250 ML	Infusion Pump
DOPAMINE 400 MG-D5W 500 ML	Infusion Pump
DOPAMINE 400 MG/250 ML-D5W BAG	Infusion Pump
DOPAMINE 800 MG/500 ML-D5W BAG	Infusion Pump
DOPAMINE 800 MG/250 ML-D5W BAG	Infusion Pump
NTG 25 MG/250 ML IN D5W	Infusion Pump
NTG 0.2 MG/ML IN D5W	Infusion Pump
NTG 100 MG/250 ML IN D5W	Infusion Pump
DOBUTAMINE 250 MG/250 ML-D5W	Infusion Pump
DOBUTAMINE 500 MG/250 ML D5W	Infusion Pump
DOBUTAMINE 1,000 MG/250 ML D5W	Infusion Pump
ONDANSETRON HCL 4 MG TABLET	Antiemetic for CINV
ONDANSETRON HCL 8 MG TABLET	Antiemetic for CINV
AZATHIOPRINE 50 MG TABLET	Immunosuppressant
TACROLIMUS 0.5 MG CAPSULE (IR)	Immunosuppressant
TACROLIMUS 1 MG CAPSULE (IR)	Immunosuppressant
TACROLIMUS 5 MG CAPSULE (IR)	Immunosuppressant
PREDNISOLONE ODT 10 MG TABLET	Immunosuppressant
PREDNISOLONE ODT 15 MG TABLET	Immunosuppressant
PREDNISOLONE ODT 30 MG TABLET	Immunosuppressant
ALBUTEROL SUL 0.63 MG/3 ML SOL	Nebulizer
ALBUTEROL SUL 1.25 MG/3 ML SOL	Nebulizer
ONDANSETRON ODT 4 MG TABLET	Antiemetic for CINV
ONDANSETRON ODT 8 MG TABLET	Antiemetic for CINV
IPRATROPIUM BR 0.02% SOLN	Nebulizer
ALBUTEROL SUL 2.5 MG/3 ML SOLN	Nebulizer
IPRAT-ALBUT 0.5-3(2.5) MG/3 ML	Nebulizer

NTG 50 MG/500 ML IN D5W	Infusion Pump
NTG 200 MG/500 ML IN D5W	Infusion Pump
DOBUTAMINE 250 MG/20 ML VIAL	Infusion Pump
DOBUTAMINE 12.5 MG/ML VIAL	Infusion Pump
MORPHINE SULFATE 1 MG/ML VIAL	Infusion Pump
ACETYLCYSTEINE 10% VIAL	Nebulizer
ACETYLCYSTEINE 20% VIAL	Nebulizer
DOPAMINE 80 MG/ML VIAL	Infusion Pump
MORPHINE 5 MG/ML VIAL	Infusion Pump
PROGRAF 0.5 MG CAPSULE	Immunosuppressant
PROGRAF 1 MG CAPSULE	Immunosuppressant
ASTAGRAF XL 0.5 MG CAPSULE	Immunosuppressant
PROGRAF 5 MG CAPSULE	Immunosuppressant
ASTAGRAF XL 1 MG CAPSULE	Immunosuppressant
ASTAGRAF XL 5 MG CAPSULE	Immunosuppressant
PROGRAF 0.2 MG GRANULE PACKET	Immunosuppressant
PROGRAF 1 MG GRANULE PACKET	Immunosuppressant
PROGRAF 5 MG/ML AMPULE	Immunosuppressant
AMBISOME 50 MG VIAL	Infusion Pump
ALBUTEROL 2.5 MG/0.5 ML SOL	Nebulizer
CYCLOSPORINE 250 MG/5 ML AMPUL	Immunosuppressant
DOPAMINE 160 MG/ML VIAL	Infusion Pump
NITROGLYCERIN 5 MG/ML VIAL	Infusion Pump
DRONABINOL 2.5 MG CAPSULE	Antiemetic for CINV
DRONABINOL 5 MG CAPSULE	Antiemetic for CINV
DRONABINOL 10 MG CAPSULE	Antiemetic for CINV
MYCOPHENOLATE 200 MG/ML SUSP	Immunosuppressant
METHYLPREDNISOLONE 4 MG TABLE	Immunosuppressant
INFUMORPH 200 MG/20 ML AMPUL	Infusion Pump
INFUMORPH 500 MG/20 ML AMPUL	Infusion Pump
EPOPROSTENOL SODIUM 0.5 MG VL	Infusion Pump
EPOPROSTENOL SODIUM 1.5 MG VL	Infusion Pump
ADRUCIL 500 MG/10 ML VIAL	Infusion Pump
ADRUCIL 2,500 MG/50 ML VIAL	Infusion Pump
ADRUCIL 5 GRAM/100 ML VIAL	Infusion Pump
METHOTREXATE 250 MG/10 ML VIAL	Oral Chemo
METHOTREXATE 1 GRAM/40 ML VIAL	Oral Chemo
VINCASAR PFS 1 MG/ML VIAL	Infusion Pump
VINCASAR PFS 2 MG/2 ML VIAL	Infusion Pump
APREPITANT 40 MG CAPSULE	Antiemetic for CINV
APREPITANT 80 MG CAPSULE	Antiemetic for CINV
APREPITANT 125 MG CAPSULE	Antiemetic for CINV
APREPITANT 125-80-80 MG PACK	Antiemetic for CINV
DEXCOM G4 TRANSMITTER KIT	Continuous Glucose Monitor
DEXCOM G5 TRANSMITTER KIT	Continuous Glucose Monitor
DEXCOM G6 TRANSMITTER	Continuous Glucose Monitor
DEXCOM G4 RECEIVER KIT	Continuous Glucose Monitor
DEXCOM G4 (PED) RECEIVER KIT	Continuous Glucose Monitor

DEXCOM G4 RECEIVER-SHARE KIT	Continuous Glucose Monitor
DEXCOM G5-G4 SENSOR KIT	Continuous Glucose Monitor
DEXCOM G6 SENSOR	Continuous Glucose Monitor
DEXCOM G4 RECEIVER-SHARE (PED)	Continuous Glucose Monitor
DEXCOM G5 RECEIVER KIT	Continuous Glucose Monitor
DEXCOM RECEIVER KIT	Continuous Glucose Monitor
DEXCOM G6 RECEIVER	Continuous Glucose Monitor
BETHKIS 300 MG/4 ML AMPULE	Nebulizer
PENTAMIDINE 300 MG INHAL POWDR	Nebulizer
SODIUM NITROPRUSSIDE 50 MG/2ML	Infusion Pump
FLUOROURACIL 500 MG/10 ML VIAL	Infusion Pump
FLUOROURACIL 1 GRAM/20 ML VIAL	Infusion Pump
FLUOROURACIL 2.5 GRAM/50 ML VL	Infusion Pump
FLUOROURACIL 5 GRAM/100 ML VL	Infusion Pump
XOPENEX CONC 1.25 MG/0.5 ML	Nebulizer
XOPENEX 0.31 MG/3 ML SOLUTION	Nebulizer
XOPENEX 0.63 MG/3 ML SOLUTION	Nebulizer
XOPENEX 1.25 MG/3 ML SOLUTION	Nebulizer
MYCOPHENOLATE 500 MG VIAL	Immunosuppressant
ONDANSETRON 2 MG/2.5 ML ENFIT	Antiemetic for CINV
ONDANSETRON 2 MG/2.5 ML SYRING	Antiemetic for CINV
PRIALT 100 MCG/ML VIAL	Infusion Pump
PRIALT 25 MCG/ML VIAL	Infusion Pump
SYNDROS 5 MG/ML SOLUTION	Antiemetic for CINV
MARQIBO KIT	Infusion Pump
CIDOFOVIR 375 MG/5 ML VIAL	Infusion Pump
MILLIPRED 5 MG TABLET	Immunosuppressant
GANCICLOVIR 500 MG/10 ML VIAL	Infusion Pump
FOSCARNET 6,000 MG/250 ML BAG	Infusion Pump
AMIODARONE 150 MG/3 ML SYRINGE	Infusion Pump
BACLOFEN 10 MG/20 ML VIAL	Infusion Pump
BACLOFEN 40 MG/20 ML VIAL	Infusion Pump
BACLOFEN 20,000 MCG/20 ML VIAL	Infusion Pump
BACLOFEN 0.05 MG/ML SYRINGE	Infusion Pump
AGGRASTAT 3.75 MG/15 ML VIAL	Infusion Pump
AGGRASTAT 5 MG/100 ML IV SOLN	Infusion Pump
AGGRASTAT 12.5 MG/250 ML	Infusion Pump
AGGRASTAT 5 MG/100 ML VIAL	Infusion Pump
AMPHOTERICIN B 50 MG VIAL	Infusion Pump
NEXTERONE 150 MG/100 ML BAG	Infusion Pump
NEXTERONE 360 MG/200 ML BAG	Infusion Pump
GUARDIAN SENSOR 3	Continuous Glucose Monitor
MINIMED 630G GUARDIAN START KT	Continuous Glucose Monitor
GUARDIAN LINK 3 TRANSMITTER	Continuous Glucose Monitor
CYTOGAM 2.5 GM/50 ML VIAL	Infusion Pump
MELPHALAN 2 MG TABLET	Oral Chemo
PERFOROMIST 20 MCG/2 ML SOLN	Nebulizer
YUPELRI 175 MCG/3 ML SOLUTION	Nebulizer

ALBUTEROL 5 MG/ML SOLUTION	Nebulizer
PULMOZYME 1 MG/ML AMPUL	Nebulizer
SIROLIMUS 1 MG TABLET	Immunosuppressant
TREXALL 5 MG TABLET	Oral Chemo
TREXALL 7.5 MG TABLET	Oral Chemo
TREXALL 10 MG TABLET	Oral Chemo
TREXALL 15 MG TABLET	Oral Chemo
NIPRIDE RTU 50 MG/100 ML VIAL	Infusion Pump
NIPRIDE RTU 10 MG/50 ML VIAL	Infusion Pump
NIPRIDE RTU 20 MG/100 ML VIAL	Infusion Pump
GANCICLOVIR 500 MG/250 ML BAG	Infusion Pump
ALKERAN 2 MG TABLET	Oral Chemo
XATMEP 2.5 MG/ML ORAL SOLUTION	Oral Chemo
IMURAN 50 MG TABLET	Immunosuppressant
ONDANSETRON HCL 24 MG TABLET	Antiemetic for CINV
SIROLIMUS 2 MG TABLET	Immunosuppressant
ACYCLOVIR 500 MG/10 ML VIAL	Infusion Pump
ACYCLOVIR 1,000 MG/20 ML VIAL	Infusion Pump
AMIODARONE 450 MG/9 ML VIAL	Infusion Pump
AMIODARONE 900 MG/18 ML VIAL	Infusion Pump
ACYCLOVIR SODIUM 500 MG VIAL	Infusion Pump
ACYCLOVIR SODIUM 1 GM VIAL	Infusion Pump
BLINCYTO 35MCG VL W-STABILIZER	Infusion Pump
VECTIBIX 100 MG/5 ML VIAL	Infusion Pump
VECTIBIX 400 MG/20 ML VIAL	Infusion Pump
FREESTYLE LIBRE 10 DAY SENSOR	Continuous Glucose Monitor
FREESTYLE LIBRE 10 DAY READER	Continuous Glucose Monitor
FREESTYLE LIBRE 14 DAY SENSOR	Continuous Glucose Monitor
FREESTYLE LIBRE 14 DAY READER	Continuous Glucose Monitor
FREESTYLE LIBRE 2 SENSOR	Continuous Glucose Monitor
FREESTYLE LIBRE 2 READER	Continuous Glucose Monitor
ABELCET 100 MG/20 ML VIAL	Infusion Pump
ENGERIX-B PEDI 10 MCG/0.5 SYRN	Hepatitis B vaccine
ENGERIX-B 20 MCG/ML VIAL	Hepatitis B vaccine
ENGERIX-B 20 MCG/ML SYRN	Hepatitis B vaccine
THYMOGLOBULIN 25 MG VIAL	Immunosuppressant
ORAPRED ODT 10 MG TABLET	Immunosuppressant
ORAPRED ODT 15 MG TABLET	Immunosuppressant
ORAPRED ODT 30 MG TABLET	Immunosuppressant
METHYLPREDNISOLONE 8 MG TAB	Immunosuppressant
METHYLPREDNISOLONE 16 MG TAB	Immunosuppressant
METHYLPREDNISOLONE 32 MG TAB	Immunosuppressant
SIROLIMUS 0.5 MG TABLET	Immunosuppressant
SIROLIMUS 1 MG/ML SOLUTION	Immunosuppressant
AZATHIOPRINE 75 MG TABLET	Immunosuppressant
AZATHIOPRINE 100 MG TABLET	Immunosuppressant
CYCLOSPORINE 25 MG CAPSULE	Immunosuppressant
CYCLOSPORINE 100 MG CAPSULE	Immunosuppressant

CYTARABINE 20 MG/ML VIAL	Infusion Pump
CYTARABINE 100 MG/5 ML VIAL	Infusion Pump
VINCRISTINE 1 MG/ML VIAL	Infusion Pump
VINCRISTINE 2 MG/2 ML VIAL	Infusion Pump
CYTARABINE 2 G/20 ML VIAL	Infusion Pump
AMPHOTERICIN B LIPOSOME 50 MG	Infusion Pump
METHOTREXATE 25 MG/ML VIAL	Oral Chemo
VINBLASTINE 1 MG/ML VIAL	Infusion Pump
FOSCARNET 6,000 MG/250 ML BTTL	Infusion Pump
NEBUPENT 300 MG INHAL POWDER	Nebulizer
BROVANA 15 MCG/2 ML SOLUTION	Nebulizer
AZASAN 75 MG TABLET	Immunosuppressant
AZASAN 100 MG TABLET	Immunosuppressant
VENTAVIS 10 MCG/1 ML SOLUTION	Nebulizer
VENTAVIS 20 MCG/1 ML SOLUTION	Nebulizer
VELETRI 1.5 MG VIAL	Infusion Pump
VELETRI 0.5 MG VIAL	Infusion Pump
TYVASO INHALATION STARTER KIT	Nebulizer
TYVASO INHALATION REFILL KIT	Nebulizer
TYVASO 1.74 MG/2.9 ML SOLUTION	Nebulizer
TYVASO INSTITUTIONAL START KIT	Nebulizer
GABLOFEN 50 MCG/ML SYRINGE	Infusion Pump
GABLOFEN 10,000 MCG/20 ML SYRG	Infusion Pump
GABLOFEN 10,000 MCG/20 ML VIAL	Infusion Pump
GABLOFEN 20,000 MCG/20 ML SYRG	Infusion Pump
GABLOFEN 20,000 MCG/20 ML VIAL	Infusion Pump
GABLOFEN 40,000 MCG/20 ML SYRG	Infusion Pump
GABLOFEN 40,000 MCG/20 ML VIAL	Infusion Pump
CYTARABINE 1000 MG/50 ML VIAL	Infusion Pump
VYXEOS 44 MG-100 MG VIAL	Infusion Pump
ENVARSUS XR 1 MG TABLET	Immunosuppressant
ENVARSUS XR 4 MG TABLET	Immunosuppressant
ENVARSUS XR 0.75 MG TABLET	Immunosuppressant
VARUBI 90 MG TABLET	Antiemetic for CINV
LIORESAL IT 10 MG/20 ML KIT	Infusion Pump
LIORESAL IT 10 MG/20 ML AMPULE	Infusion Pump
LIORESAL IT 10 MG/5 ML KIT	Infusion Pump
LIORESAL IT 10 MG/5 ML AMPULE	Infusion Pump
LIORESAL IT 0.05 MG/1 ML AMP	Infusion Pump
LIORESAL IT 40 MG/20 ML KIT	Infusion Pump
LIORESAL IT 40 MG/20 ML AMPULE	Infusion Pump
VARUBI 180 MG DOSE(2X 90MG TB)	Antiemetic for CINV
PRIALT 500 MCG/5 ML VIAL	Infusion Pump
PRIALT 500 MCG/20 ML VIAL	Infusion Pump
OLINVYK 30 MG/30 ML PCA VIAL	Infusion Pump
PREHEVBRIO 10 MCG/ML VIAL	Hepatitis B vaccine
PHOTOFRIN 75 MG VIAL	Infusion Pump
ENLITE GLUCOSE SENSOR	Continuous Glucose Monitor

PARADIGM REAL-TIME SYSTEM	Continuous Glucose Monitor
GUARDIAN REAL-TIME GLU MONITOR	Continuous Glucose Monitor
MINILINK REAL-TIME TRANSMITTER	Continuous Glucose Monitor
ENLITE SYSTEM KIT	Continuous Glucose Monitor
FOSCAVIR 6,000 MG/250 ML BTTL	Infusion Pump
FOSCAVIR 6,000 MG/250 ML BAG	Infusion Pump
MORPHINE 30 MG/30 ML PCA VIAL	Infusion Pump
ZUPLENZ 4 MG SOLUBLE FILM	Antiemetic for CINV
ZUPLENZ 8 MG SOLUBLE FILM	Antiemetic for CINV
FREESTYLE NAVIGATOR SENSOR KIT	Continuous Glucose Monitor
CYCLOPHOSPHAMIDE 25 MG TABLET	Oral Chemo
CYCLOPHOSPHAMIDE 50 MG TABLET	Oral Chemo
KITABIS PAK 300 MG/5 ML	Nebulizer

HIGHMARK DELAWARE

January 1 – December 31, 2023

Evidence of Coverage:

Your Medicare Health Benefits and Services as a Member of Freedom Blue PPO

This document gives you the details about your Medicare health care coverage from January 1 – December 31, 2023. **This is an important legal document. Please keep it in a safe place.**

For questions about this document, please contact our Member Service number at 1-888-328-2960. (TTY users should call 711 National Relay Service). Hours are Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time.

This plan, Freedom Blue PPO, is offered by Highmark BCBSD, INC.. (When this *Evidence of Coverage* says "we," "us," or "our," it means Highmark BCBSD, INC.. When it says "plan" or "our plan," it means Freedom Blue PPO.)

This information is available in alternate formats such as large print.

Benefits required by Medicare may change on January 1, 2024.

The provider network may change at any time. You will receive notice when necessary. We will notify affected enrollees about changes at least 30 days in advance.

This document explains your benefits and rights. Use this document to understand about:

- Your cost sharing;
- Your medical benefits;
- How to file a complaint if you are not satisfied with a service or treatment;
- How to contact us if you need further assistance; and,
- Other protections required by Medicare law.

OMB Approval 0938-1051 (Expires: February 29, 2024)

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2023 Evidence of Coverage

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CHAPTER 1:

Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in Freedom Blue PPO, which is a Medicare PPO

You are covered by Medicare, and you have chosen to get your Medicare health care coverage through our plan, Freedom Blue PPO. We are required to cover all Part A and Part B services. However, cost sharing and provider access in this plan differ from Original Medicare.

Freedom Blue PPO is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company. This plan does not include Part D prescription drug coverage.

Coverage under this Plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at: www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

Section 1.2 What is the *Evidence of Coverage* document about?

This *Evidence of Coverage* document tells you how to get your medical care. It explains your rights and responsibilities, what is covered, what you pay as a member of the plan, and how to file a complaint if you are not satisfied with a decision or treatment.

The word "coverage" and "covered services" refers to the medical care and services available to you as a member of Freedom Blue PPO.

It's important for you to learn what the plan's rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* document.

If you are confused or concerned or just have a question, please contact Member Service.

Section 1.3 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how Freedom Blue PPO covers your care. Other parts of this contract include your enrollment form and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for months in which you are enrolled in Freedom Blue PPO between January 1, 2023 and December 31, 2023.

Medicare (the Centers for Medicare & Medicaid Services) must approve Freedom Blue PPO each year. You can continue each year to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

SECTION 2 What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

You are eligible for membership in our plan as long as:

- You have both Medicare Part A and Medicare Part B
- -- *and* -- you live in our geographic service area (Section 2.2 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.
- -- *and* -- you are a United States citizen or are lawfully present in the United States
- you and your dependent(s) must meet the State of Delaware eligibility for Medicare retiree benefits

Section 2.2 Here is the plan service area for Freedom Blue PPO

Freedom Blue PPO is available only to individuals who live in the United States and its territories. To remain a member of our plan, you must continue to reside in the United States and its territories. The service area is described in Chapter 3, section 2.2 *Blue Cross Blue Shield Association Network Sharing* and the *Network Sharing* appendix in the back of this document.

If you plan to move out of the United States or its territories, you cannot remain a member of this plan. Please contact Member Service or your group administrator. When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

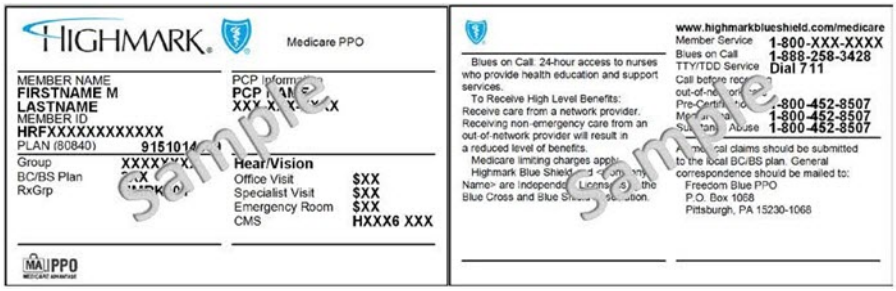
Section 2.3 U.S. Citizen or Lawful Presence

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify Freedom Blue PPO if you are not eligible to remain a member on this basis. Freedom Blue PPO must disenroll you if you do not meet this requirement.

SECTION 3 Important membership materials you will receive

Section 3.1 Your plan membership card

While you are a member of our plan, you must use your membership card whenever you get services covered by this plan. You should also show the provider your Medicaid card, if applicable. Here’s a sample membership card to show you what yours will look like:



Do NOT use your red, white, and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your Freedom Blue PPO membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare approved clinical research studies also called clinical trials.

If your plan membership card is damaged, lost, or stolen, call Member Service right away and we will send you a new card.

Section 3.2 Provider Directory

The *Provider Directory* lists our network providers and durable medical equipment suppliers. **Network providers** are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full.

If you use out-of-network providers that do not submit claims to their local Blue Cross Blue Shield or to Highmark, they may ask you to pay in full. The only exceptions are emergencies, urgently needed services when the network is not available (that is, in situations when it is unreasonable or not possible to obtain services in-network), out-of-area dialysis services, and cases in which Freedom Blue PPO authorizes use of out-of-network providers. **For additional information on out-of-network providers, please see Chapter 3, Section 2.5.**

If you don't have your copy of the *Provider Directory*, you can request a copy from Member Service.

SECTION 4 Your monthly costs for Freedom Blue PPO

Your costs may include the following:

- Monthly Part B Premium (Section 4.2)

Medicare Part B premiums differ for people with different incomes. If you have questions about these premiums review your copy of *Medicare & You 2023* handbook, the section called "2023 Medicare Costs." If you need a copy, you can download it from the Medicare website (www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.1 Plan premium

Please contact the State of Delaware for more information about the premium for this plan.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

You must continue paying your Medicare premiums to remain a member of the plan. This includes your premium for Part B. It may also include a premium for Part A which affects members who aren't eligible for premium free Part A.

SECTION 5 More information about your monthly premium

Section 5.1 Can we change your monthly plan premium during the year?

No. Unless the State of Delaware makes a change, we are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year, the State of Delaware will tell you in your open enrollment communications for the State of Delaware and the change will take effect on January 1.

SECTION 6 Keeping your plan membership record up to date

Your membership record has information from your enrollment, including your address and telephone number. It shows your specific plan coverage including your Primary Care Provider.

The doctors, hospitals, and other providers in the plan's network need to have correct information about you. **These network providers use your membership record to know what services are covered and the cost sharing amounts for you**. Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If you receive care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes

- If you are participating in a clinical research study. (**Note:** You are not required to tell your plan about the clinical research studies you intend to participate in, but we encourage you to do so).

If any of this information changes, please let us know by calling Member Service.

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

SECTION 7 How other insurance works with our plan

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. This is called **Coordination of Benefits**.

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Member Service. You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that pays second, called the "secondary payer," only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs. If you have other insurance, tell your doctor, hospital, and pharmacy.

These rules apply for employer or union/trust fund group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
  - If you're under 65 and disabled and you or your family member is still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
  - If you're over 65 and you or your spouse is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)

- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

CHAPTER 2:

Important phone numbers and resources

SECTION 1 Freedom Blue PPO contacts (How to contact us, including how to reach Member Service)

How to contact our plan's Member Service

For assistance with claims, billing or member card questions, please call or write to Member Service. We will be happy to help you.

Method	Member Service – Contact Information
CALL	1-888-328-2960 Calls to this number are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time. Member Service also has free language interpreter services available for non-English speakers.
TTY	711 National Relay Service This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time.
FAX	1-717-635-4235
WRITE	P.O. Box 1068 Pittsburgh, PA 15230-1068
WEBSITE	medicare.highmark.com

How to contact us when you are asking for a coverage decision or appeal about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on asking for coverage decisions or appeals about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Coverage Decisions for Medical Care – Contact Information
CALL	1-800-452-8507, option 2 Calls to this number are free. Monday through Friday, 8:30 a.m. to 7:00 p.m., Saturday and Sunday, 8:30 a.m. to 4:30 p.m., Eastern Time. To file an expedited medical organization determination, call 1-800-485-9610, option 2.

Method	Coverage Decisions for Medical Care – Contact Information
TTY	711 National Relay Service This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Friday, 8:30 a.m. to 7:00 p.m., Saturday and Sunday, 8:30 a.m. to 4:30 p.m., Eastern Time.
FAX	1-800-894-7947
WRITE	P.O. Box 1068 Pittsburgh, PA 15230-1068 To file an expedited organization determination, send your request to: Appeals and Grievance Dept. P.O. Box 535047 Pittsburgh, PA 15253-5047
WEBSITE	medicare.highmark.com

Method	Appeals for Medical Care – Contact Information
CALL	1-888-328-2960 Calls to this number are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time. To file an expedited appeal, call NY_Table.Appeals_Med_Care_Phone_Expedited.
TTY	711 National Relay Service This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time.
FAX	1-717-635-4209 To file an expedited appeal, fax your request to 1-800-894-7947.
WRITE	Appeals and Grievance Dept. P.O. Box 535047 Pittsburgh, PA 15253-5047
WEBSITE	medicare.highmark.com

How to contact us when you are making a complaint about your medical care

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. For more information on making a complaint about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

Method	Complaints About Medical Care – Contact Information
CALL	1-888-328-2960 Calls to this number are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time.
TTY	711 National Relay Service This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time.
FAX	1-717-635-4209
WRITE	Appeals and Grievance Dept. P.O. Box 535047 Pittsburgh, PA 15253-5047
MEDICARE WEBSITE	You can submit a complaint about directly to Medicare. To submit an online complaint to Medicare go to www.medicare.gov/MedicareComplaintForm/home.aspx.

Where to send a request asking us to pay for our share of the cost for medical care you have received

If you have received a bill or paid for services (such as a provider bill) that you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill, see Chapter 5 (*Asking us to pay our share of a bill you have received for covered medical services*).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 7 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* for more information.

Method	Payment Requests – Contact Information
CALL	1-888-328-2960 Calls to this number are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time.

Method	Payment Requests – Contact Information
TTY	711 National Relay Service This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time.
FAX	1-717-635-4235
WRITE	P.O. Box 1068 Pittsburgh, PA 15230-1068
WEBSITE	medicare.highmark.com

SECTION 2 Medicare
(how to get help and information directly from the Federal Medicare program)

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called "CMS"). This agency contracts with Medicare Advantage organizations including us.

Method	Medicare – Contact Information
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	www.medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home

Method	Medicare – Contact Information
	health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about Freedom Blue PPO: • **Tell Medicare about your complaint:** You can submit a complaint about Freedom Blue PPO directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website and review the information with you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

SECTION 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. Please refer to the ***Agency Contact Information*** appendix in the back of this document for a list of SHIP contact information by state.

SHIP is an independent (not connected with any insurance company or health plan) state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

SHIP counselors can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. SHIP counselors can also help you with Medicare questions or problems and help you understand your Medicare plan choices and answer questions about switching plans.

METHOD TO ACCESS SHIP and OTHER RESOURCES:

- Visit *www.medicare.gov*
- Click on "**Talk to Someone**" in the middle of the homepage
- You now have the following options
  - Option #1: You can have a **live chat with a 1-800-MEDICARE representative**
  - Option #2: You can select your **STATE** from the dropdown menu and click GO. This will take you to a page with phone numbers and resources specific to your state.

SECTION 4 Quality Improvement Organization

There is a designated Quality Improvement Organization (QIO) for serving Medicare beneficiaries in each state. Please refer to the ***Agency Contact Information*** appendix in the back of this document for a list of QIO contact information by state.

QIO has a group of doctors and other health care professionals who are paid by Medicare to check on and help improve the quality of care for people with Medicare. QIO is an independent organization. It is not connected with our plan.

You should contact QIO in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or ESRD and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

If you move or change your mailing address, it is important that you contact Social Security to let them know.

Method	Social Security– Contact Information
CALL	1-800-772-1213 Calls to this number are free. Available 8:00 a.m. to 7:00 p.m., Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8:00 a.m. to 7:00 p.m., Monday through Friday.
WEBSITE	www.ssa.gov

SECTION 6 Medicaid

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. The programs offered through Medicaid help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" include:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Qualifying Individual (QI):** Helps pay Part B premiums
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums

To find out more about Medicaid and its programs, please refer to ***Agency Contact Information*** appendix in the back of this document for a list of Medicaid contact information by state.

SECTION 7 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

Method	Railroad Retirement Board – Contact Information
CALL	1-877-772-5772 Calls to this number are free. If you press "0," you may speak with an RRB representative from 9:00 a.m. to 3:30 p.m., Monday, Tuesday, Thursday, and Friday, and from 9:00 a.m. to 12:00 p.m. on Wednesday. If you press "1", you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.
WEBSITE	rrb.gov/

SECTION 8 Do you have "group insurance" or other health insurance from an employer?

As a State of Delaware retiree healthcare plan participant, you may call the State of Delaware Office of Pensions or your participating group that manages your retiree benefits. Call if you have any questions on your retiree health benefits including:

- retiree health plan eligibility
- you or your spouse/dependent(s) are eligible for other health insurance benefits
- plan premiums
- information about the annual enrollment period.

Call the office that manages your retiree benefits.

Office of Pensions	1-302-739-4208 or 1-800-722-7300
City of Dover	1-302-736-7790
City of Rehoboth Beach	1-302-722-8194
Delaware Transit Corporation (DART)	1-302-576-6082
Delaware State Housing Authority	1-302-739-0260
Town of Smyrna	1-302-389-2320
University of Delaware	1-302-831-2171

You may also call 1-800-MEDICARE (1-800-633-4227; TTY:1-877-486-2048) with questions related to your Medicare coverage under this plan.

CHAPTER 3:

Using the plan's coverage for your medical services

SECTION 1 Things to know about getting your medical care as a member of our plan

This chapter explains what you need to know about using the plan to get your medical care covered. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, equipment, prescription drugs, and other medical care that are covered by the plan.

For the details on what medical care is covered by our plan and how much you pay when you get this care, use the *Medical Benefits Chart* appendix and Chapter 4 (*Medical Benefits Chart*, *what is covered and what you pay*).

Section 1.1 What are "network providers" and "covered services"?

- **"Providers"** are doctors and other health care professionals licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.
- **"Network providers"** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.
- **"Covered services"** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the *Medical Benefits Chart* appendix.

Section 1.2 Basic rules for getting your medical care covered by the plan

As a Medicare health plan, Freedom Blue PPO must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

Freedom Blue PPO will generally cover your medical care as long as:

- **The care you receive is included in the plan's *Medical Benefits Chart* appendix.**
- **The care you receive is considered medically necessary**. "Medically necessary" means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You receive your care from a provider who is eligible to provide services under Original Medicare.** As a member of our plan, you can receive your care from either a network provider or an out-of-network provider (for more about this, see Section 2 in this chapter).
  - The providers in our network are listed in the *Provider Directory*.
  - If you use an out-of-network provider, your share of the costs for your covered services will be the same for Medicare benefits as a network provider.

- Please note: While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you go to a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.

SECTION 2 Using network and out-of-network providers to get your medical care

Section 2.1 You may choose a Primary Care Provider (PCP) to provide and oversee your medical care

What is a "PCP" and what does the PCP do for you?

When you become a member of Freedom Blue PPO, you may choose a plan provider to be your PCP. Your PCP is a family physician, general practitioner or internal medicine physician who meets state requirements and is trained to give you basic medical care. A PCP can also be a physician assistant or nurse practitioner. Your PCP is much like the "old-fashioned family doctor" – one who knows your current health as well as your medical history; a provider with whom you feel comfortable discussing all of your health care needs. You will get your routine or basic care from this provider. Your PCP can also help coordinate the rest of the covered services you get as a member of Freedom Blue PPO. Coordinating your services includes checking or consulting with other plan providers about your care and how it is going. You are encouraged, but not required to see your PCP whenever you need care. This helps ensure that you receive the right care for your needs, when you need it. For your convenience and security, network primary care physicians or their covering doctors are on call 24 hours a day, seven days a week.

How do you choose your PCP?

PCPs and their group practices, if applicable, are listed in the *Provider Directory*. You can also find PCPs on our website at medicare.highmark.com. Click on the "Find a Provider" link to access our online *Provider Directory*. Because your PCP plays a central role in your health care, please select one with careful consideration to hospital affiliation and office location.

To view board certification information and the hospital affiliation of your PCP or Network specialist, visit our website at medicare.highmark.com. Click on the "Find a Provider" link to access our online *Provider Directory*. Search for the physician, then click on the provider's name to view this information. In addition to this information, to obtain the full professional qualifications of network providers, including medical schools attended and residencies completed, call Member Service.

Simply call Member Service to add your PCP selection to your file.

Changing your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP.

To change your PCP, contact Member Service. They will check to be sure the PCP you want is accepting new patients. Member Service will also request the change to your membership record to show the name of the new PCP.

- If your request for change is received between the 1st and the 15th day of the month, your PCP change will become effective the first day of the following month.
- If your request for change is received between the 16th and last day of the month, your PCP change will become effective the first day of the second month after it is received.

Section 2.2 How to get care from specialists and other network providers

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart conditions.
- Orthopedists care for patients with certain bone, joint, or muscle conditions.

We list the specialists and other network providers that participate with Freedom Blue PPO in the *Provider Directory*. You can also locate participating network providers on our website, medicare.highmark.com. While you are not required to get a referral from your PCP prior to receiving covered specialty care, you are encouraged to coordinate and record your treatment with your PCP at each stage of your care. This way, you can be sure that your need for specialty care is based on an informed diagnosis. Your PCP can direct you to the right specialist promptly, so you don't waste time tracking down the best doctor for your case. You also can be confident that your specialty care will complement other care you may be receiving. Certain services, such as non-emergency inpatient hospital care, require prior authorization from Freedom Blue PPO for the service to be covered. Network providers are responsible for obtaining this prior authorization (for more information on which services require prior authorization, see the *Medical Benefits Chart* appendix).

If you believe you need **treatment for mental health or substance abuse**, contact the network behavioral health provider of your choice or call Member Service at the toll-free / TTY number on the back of your member ID card and select the *mental health, drug or alcohol treatment services* option from the menu. You will be connected to Highmark Behavioral Health Department, which is available Monday through Friday, 8:30 a.m. through 7:00 p.m., Eastern Time.

What if a specialist or another network provider leaves our plan?

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. If your doctor or specialist leaves your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If our network does not have a qualified specialist for a plan-covered service, we must cover that service at in-network cost sharing (prior authorization may be required).
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file a quality of care complaint to the QIO, a quality of care grievance to the plan, or both. Please see Chapter 7.

Section 2.3 Blue Cross Blue Shield Association Network Sharing

Freedom Blue PPO members have access to the Blue Cross Blue Shield Association service area providers. Freedom Blue PPO members may visit any participating Blue Cross and/or Blue Shield Medicare Advantage PPO provider in any geographic area where the Part A, Part B and supplemental services of Blue Cross Blue Shield providers are offered, and pay network cost sharing.

The Service Area includes specific counties in the following 48 states and 2 territories: Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, and West Virginia. For some of the states listed, Medicare Advantage PPO networks are only available in portions of the state. ***See the Network Sharing appendix in the back of this book for a list of BCBSA network sharing counties by state.***

To find Blue Cross and/or Blue Shield Medicare Advantage PPO providers in the above locations, you may:

- Call Freedom Blue PPO Member Service (numbers on the back of your ID card), Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time. Hearing-impaired TTY users call 711 National Relay Service.
- Visit medicare.highmark.com and select "Find Providers" or visit "Find a Doctor" at www.BCBS.com.

Freedom Blue PPO members may see any Blue Cross and/or Blue Shield Medicare Advantage PPO contracted doctor or hospital outside the Freedom Blue PPO service area in the above locations and receive coverage at the same level of benefits.

In locations where participating Blue Cross and/or Blue Shield Medicare Advantage PPO providers are not available, members may visit **any Medicare-eligible provider** and receive coverage at the same level of benefits.

Emergency and urgently needed care is always covered at the higher network level of benefits, regardless of where the care is received.

You can get your care from an out-of-network provider, however, in most cases that provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you receive care from a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.

Section 2.4 What you pay for covered services

The following charts are for members **who live** within a county that includes participating Blue Cross and/or Blue Shield Medicare Advantage providers.

While at home, you can go to the following providers and receive:

Network Doctors and Hospitals	Non-Network Doctors and Hospitals
Full coverage for all Medicare benefits	Full coverage for all Medicare benefits

When traveling outside of your county or across the country, you can go to the following providers and receive:

If you seek care in a county…	Network Doctors/Hospitals	Non-Network Doctors/Hospitals
***With* a participating Medicare Advantage PPO network**	Full coverage for all Medicare benefits	Full coverage for all Medicare benefits
***Without* a participating Medicare Advantage PPO network**	Full coverage for all Medicare benefits	Full coverage for all Medicare benefits

The following charts are for members who **do not live** in a county that includes participating Blue Cross and/or Blue Shield Medicare Advantage providers.

While at home, you can go to any Medicare participating provider in your county and receive:

Network Doctors and Hospitals	Non-Network Doctors and Hospitals
Covered in full.	Full coverage for all Medicare benefits

When traveling outside of your county or across the country, you can go to the following providers and receive:

If you seek care in a county…	Network Doctors/Hospitals	Non-Network Doctors/Hospitals
***With* a participating Medicare Advantage PPO network**	Full coverage for all Medicare benefits	Full coverage for all Medicare benefits
***Without* a participating Medicare Advantage PPO network**	Full coverage for all Medicare benefits	Full coverage for all Medicare benefits

When you call a provider's office to make an appointment, be sure to tell them that you have coverage through a Blue Cross and/or Blue Shield Medicare Advantage PPO. And when you visit, show them your Freedom Blue PPO ID card. It's important that you show your Freedom Blue PPO ID card to the provider when you seek medical care. Your card has a special "suitcase" in the lower left corner of the card. This suitcase alerts your doctor, hospital or other provider that you are a member of a Blue Cross and/or Blue Shield Medicare Advantage PPO. It also directs them to file any claims for services they provide to their local Blue Cross and/or Blue Shield Plan.

The cost of the service, on which member liability (copayment/coinsurance) is based, will be either:

- The Medicare allowable amount for covered services, or
- The amount either Highmark Blue Shield negotiates with the provider or the local Blue Medicare Advantage plan negotiates with its provider on behalf of our members, if applicable. The amount negotiated may be either higher than, lower than, or equal to the Medicare allowable amount.

Section 2.5 How to get care from out-of-network providers

As a member of our plan, you can choose to receive care from out-of-network providers. However, please note providers that do not contract with us are under no obligation to treat you, except in emergency situations. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and are medically necessary. Here are other important things to know about using out-of-network providers:

- You can get your care from an out-of-network provider, however, in most cases that provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you receive care from a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.
- You don't need to get a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers you may want to ask for a pre-visit coverage decision to confirm that the services you are getting are covered

and are medically necessary. (See Chapter 7, Section 4 for information about asking for coverage decisions.) This is important because:

- Without a pre-visit coverage decision, if we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. See Chapter 7 *(What to do if you have a problem or complaint)* to learn how to make an appeal.

- It is best to ask an out-of-network provider to bill the plan first. But, if you have already paid for the covered services, we will reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill that you think we should pay, you can send it to us for payment. See Chapter 5 (*Asking us to pay our share of a bill you have received for covered medical services*) for information about what to do if you receive a bill or if you need to ask for reimbursement.
- If you are using an out-of-network provider for emergency care, urgently needed services, or out-of-area dialysis, you will have the same level of benefits as using a network provider. See Section 3 for more information about these situations.

SECTION 3 How to get services when you have an emergency or urgent need for care or during a disaster

Section 3.1 Getting care if you have a medical emergency

What is a "medical emergency" and what should you do if you have one?

A **"medical emergency"** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent your loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP. You do not need to use a network doctor. You may get covered emergency medical care whenever you need it, anywhere in the United States, its territories or worldwide, and from any provider with an appropriate state license even if they are not part of our network.

What is covered if you have a medical emergency?

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency.

The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us and make plans for additional care. Your follow-up care will be covered by our plan.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all. If it turns out that it was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.

Section 3.2 Getting care when you have an urgent need for services

What are "urgently needed services"?

An urgently needed service is a non-emergency situation requiring immediate medical care but given your circumstances, it is not possible or not reasonable to obtain these services from a network provider. The plan must cover urgently needed services provided out of network. Some examples of urgently needed services are i) a severe sore throat that occurs over the weekend or ii) an unforeseen flare-up of a known condition when you are temporarily outside the service area.

If you believe you have an urgent need for care, go to the nearest emergency room or urgent care facility. Urgent care centers can be located in the *Provider Directory* or at medicare.highmark.com. See the *Medical Benefits Chart* appendix for more information.

Our plan covers worldwide emergency and urgent care services outside the United States under the following circumstances:

- injury
- sudden illness
- medical condition that is quickly getting worse

Section 3.3 Getting care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from your plan.

Please visit the following website: medicare.highmark.com for information on how to obtain needed care during a disaster.

SECTION 4 What if you are billed directly for the full cost of your services?

Section 4.1 You can ask us to pay our share of the cost of covered services

If you have paid more than your plan cost sharing for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 5 (*Asking us to pay our share of a bill you have received for covered medical services*) for information about what to do.

Section 4.2 If services are not covered by our plan, you must pay the full cost

Freedom Blue PPO covers all medically necessary services as listed in the *Medical Benefits Chart* appendix. If you receive services not covered by our plan, you are responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you have used up your benefit for that type of covered service. These payments will not count toward your out-of-pocket maximum. You can call Member Service when you want to know how much of your benefit limit you have already used.

SECTION 5 How are your medical services covered when you are in a "clinical research study"?

Section 5.1 What is a "clinical research study"?

A clinical research study (also called a "clinical trial") is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically request volunteers to participate in the study.

Once Medicare approves the study, and you express interest, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study *and* you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. If you tell us that you are in a qualified clinical trial, then you are only responsible for the in-network cost sharing for the services in that trial. If you paid more, for example, if you already paid the Original Medicare cost sharing amount, we will reimburse the difference between what you paid and the in-network cost sharing. However, you will need to provide documentation to show us how much you paid. When you are in a clinical

research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in any Medicare-approved clinical research study, you do not need to tell us or to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do not need to be part of our plan's network of providers.

Although you do not need to get our plan's permission to be in a clinical research study, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

If you participate in a study that Medicare has *not* approved, *you will be responsible for paying all costs for your participation in the study*.

Section 5.2 When you participate in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you receive as part of the study, including:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure if it is part of the research study.
- Treatment of side effects and complications of the new care.

After Medicare has paid its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan. However, you are required to submit documentation showing how much cost sharing you paid. Please see Chapter 7 for more information for submitting requests for payments.

Here's an example of how the cost sharing works: Let's say that you have a lab test that costs $100 as part of the research study. Let's also say that your share of the costs for this test is $20 under Original Medicare, but the test would be $0 under our plan's benefits. In this case, Original Medicare would pay $80 for the test, and you would pay the $20 copay required under Original Medicare. You would then notify your plan that you received a qualified clinical trial service and submit documentation such as a provider bill to the plan. The plan would then directly pay you $20. Therefore, your net payment is $0, which is the same amount you would pay under our plan's benefits. Please note that in order to receive payment from your plan, you must submit documentation to your plan such as a provider bill.

When you are part of a clinical research study, **neither Medicare nor our plan will pay for any of the following:**

- Generally, Medicare will *not* pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were *not* in a study.

- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.

Do you want to know more?

You can get more information about joining a clinical research study by visiting the Medicare website to read or download the publication "Medicare and Clinical Research Studies". The publication is available at: www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf.) You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 6 Rules for getting care in a "religious non-medical health care institution"

Section 6.1 What is a religious non-medical health care institution?

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

Section 6.2 Receiving Care from a Religious Non-Medical Health Care Institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you are conscientiously opposed to getting medical treatment that is "non-excepted."

- "Non-excepted" medical care or treatment is any medical care or treatment that is *voluntary* and *not required* by any federal, state, or local law.
- "Excepted" medical treatment is medical care or treatment that you get that is *not* voluntary or *is required* under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
  - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
  - – *and* – you must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

All Medicare Inpatient Hospital coverage limits apply. See the *Medical Benefits Chart* appendix for details.

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 Will you own the durable medical equipment after making a certain number of payments under our plan?

Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of Freedom Blue PPO, however, you usually will not acquire ownership of rented DME items no matter how many payments the plan makes for the item while a member of our plan, even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under certain limited circumstances, we will transfer ownership of the DME item to you. Call Member Service for more information.

What happens to payments you made for durable medical equipment if you switch to Original Medicare?

If you did not acquire ownership of the DME item while in our plan, you will have to make 13 new consecutive payments after you switch to Original Medicare in order to own the item. The payments made while enrolled in your plan do not count.

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare do not count. You will have to make 13 payments to our plan before owning the item.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You were in our plan but did not obtain ownership while in our plan. You then go back to Original Medicare. You will have to make 13 consecutive new payments to own the item once you join Original Medicare again. All previous payments (whether to our plan or to Original Medicare) do not count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage, Freedom Blue PPO will cover:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents

- Tubing and related oxygen accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

If you leave Freedom Blue PPO or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

What happens if you leave your plan and return to Original Medicare?

Original Medicare requires an oxygen supplier to provide you services for five years. During the first 36 months you rent the equipment. The remaining 24 months the supplier provides the equipment and maintenance (you still have a $0 copayment for oxygen). After five years you may choose to stay with the same company or go to another company. At this point, the five-year cycle begins again, even if you remain with the same company, requiring you to pay copayments (based on your benefit coverage at the time) for the first 36 months. If you join or leave our plan, the five-year cycle starts over.

CHAPTER 4:

Medical Benefits Chart (what is covered and what you pay)

SECTION 1 Understanding your out-of-pocket costs for covered services

This chapter focuses on your covered services. The *Medical Benefits Chart* appendix lists your covered services and shows how much you will pay for each covered service as a member of Freedom Blue PPO. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

Section 1.1 Types of out-of-pocket costs you may pay for your covered services

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

- A **"copayment"** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The *Medical Benefits Chart* appendix tells you more about your copayments.)
- **"Coinsurance"** is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The *Medical Benefits Chart* appendix tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable.

Section 1.2 What is the most you will pay for Medicare Part A and Part B covered medical services?

Under our plan, there are two different limits on what you have to pay out-of-pocket for covered medical services (please see the *Medical Benefits Chart* appendix for your group's specific maximum amount):

- Your **in-network maximum out-of-pocket amount** can be found in the *Medical Benefits Chart* appendix. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from network providers. The amounts you pay for deductibles (if applicable), copayments, and coinsurance for covered services from network providers count toward this in-network maximum out-of-pocket amount. (The amounts you pay for services from out-of-network providers do not count toward your in-network maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your in-network maximum out-of-pocket amount. These services are noted as such in the *Medical Benefits Chart* appendix.) If you have paid the maximum for covered Part A and Part B services from network providers, you will not have any out-of-pocket costs for the rest of the year when you see our network providers. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

- Your **combined maximum out-of-pocket amount** can be found in the *Medical Benefits Chart* appendix. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from both in-network and out-of-network providers. The amounts you pay for deductibles (if applicable), copayments, and coinsurance for covered services count toward this combined maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your combined maximum out-of-pocket amount. These services are noted as such in the *Medical Benefits Chart* appendix.) If your combined maximum amount for covered services has been met, you will have 100% coverage and will not have any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Our plan does not allow providers to "balance bill" you

As a member of Freedom Blue PPO, an important protection for you is that you only have to pay your cost sharing amount when you get services covered by our plan. Providers may not add additional separate charges for Medicare-covered services in the United States or its territories , called "balance billing." This protection applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.

Here is how this protection works.

- If your cost sharing is a copayment (a set amount of dollars, for example, $0.00), then you will not have any cost sharing for any covered services from an in or out-of-network provider.
- If your cost sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
    - If you receive the covered services from a network provider, you pay the 0% coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
    - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the 0% coinsurance percentage multiplied by the Medicare payment rate for participating providers.
    - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the 0% coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- If you believe a provider has "balance billed" you, call Member Service.

Members that utilize the foreign travel routine care coverage benefit could be liable for a balance bill after the member pays their share of costs for services if the foreign provider charges more than Medicare-allowed amount.

SECTION 2 Use the *Medical Benefits Chart* to find out what is covered for you and how much you will pay

The *Medical Benefits Chart* appendix which lists your covered services is provided separately with the open enrollment materials and in the Welcome Kit when you first joined the plan. It is then provided every year with the Annual Notice of Change (ANOC) you receive during the Annual Election Period.

SECTION 3 What services are not covered by the plan?

Section 3.1 Services we do *not* cover (exclusions)

This section tells you what services are "excluded" from Medicare coverage and therefore, are not covered by this plan.

The chart below lists services and items that either are not covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you receive the excluded services at an emergency facility, the excluded services are still not covered, and our plan will not pay for them. The only exception is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 7, Section 5.3 in this document.)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Acupuncture		Available for people with chronic low back pain under certain circumstances.
Cosmetic surgery or procedures		• Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. • Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Custodial care Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.	✓	
Experimental medical and surgical procedures, equipment, and medications. Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.		May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)
Fees charged for care by your immediate relatives or members of your household.	✓	
Full-time nursing care in your home.	✓	
Home-delivered meals		Some limited coverage provided upon discharge from an inpatient hospital stay. See your *Medical Benefits Chart*.
Homemaker services include basic household assistance, such as light housekeeping or light meal preparation.	✓	
Naturopath services (uses natural or alternative treatments).	✓	
Non-routine dental care		Dental care required to treat illness or injury may be covered as inpatient or outpatient care.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Orthopedic shoes or supportive devices for the feet		Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	✓	
Private room in a hospital.		Covered only when medically necessary.
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	✓	
Routine chiropractic care		Manual manipulation of the spine to correct a subluxation is covered.
Routine dental care, such as cleanings, filling or dentures.	✓	
Routine eye examinations and eyeglasses		Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery.
Routine foot care		Some limited coverage provided according to Medicare guidelines, e.g., if you have diabetes.
Routine hearing exams, hearing aids, or exams to fit hearing aids. Includes hearing aid service provider visits for the following: ear molds, hearing aid accessories, return fees, warranty claim fees, and hearing aid batteries not included with the initial purchase of the aid	✓	
Services considered not reasonable and necessary,	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
according to Original Medicare standards		
Telehealth services other than those listed in the *Medical Benefits Chart* appendix.	✓	
Vision - Radial keratotomy, LASIK surgery, vision therapy and other low vision aids.	✓	

CHAPTER 5:

Asking us to pay our share of a bill you have received for covered medical services

CHAPTER 5. Asking us to pay our share of a bill you have received for covered medical services

SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered services

Sometimes when you get medical care, you may need to pay the full cost. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. Or you may receive a bill from a provider. In these cases, you can ask our plan to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services that are covered by our plan. There may be deadlines that you must meet to get paid back. Please see Section 2 of this chapter.

There may also be times when you get a bill from a provider for the full cost of medical care you have received or possibly for more than your share of cost sharing as discussed in the document. First try to resolve the bill with the provider. If that does not work, send the bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly. If we decide not to pay it, we will notify the provider. You should never pay more than plan-allowed cost sharing. If this provider is contracted, you still have the right to treatment.

Here are examples of situations in which you may need to ask our plan to pay you back or to pay a bill you have received:

1. **When you've received medical care from a provider who is not in our plan's network**

   When you received care from a provider who is not part of our network, you are only responsible for paying your share of the cost. Ask the provider to bill the plan for our share of the cost.

   - You have no cost share for emergency or urgently needed services. Emergency providers are legally required to provide emergency care. If you accidentally pay the entire amount yourself at the time you receive the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
   - You may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
     - If the provider is owed anything, we will pay the provider directly.
     - If you have already paid more than your $0 cost share, we will pay you back for our share of the cost.
   - Please note: While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If the provider is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive.

2. **When a network provider sends you a bill you think you should not pay**

   Network providers should always bill the plan directly. But sometimes they make mistakes and ask you to pay more than your share.

- You only have to pay your cost sharing amount when you get covered services (which is $0 for Medicare-covered benefits). We do not allow providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your cost sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.
- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

3. If you are retroactively enrolled in our plan

Sometimes a person's enrollment in the plan is retroactive. (This means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered services after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork such as receipts and bills for us to handle the reimbursement.

4. If you've paid for a flu shot

Flu shots can be given in a provider's office or in another setting such as a community flu shot clinic. Flu shots given in a provider's office and billed directly to Freedom Blue PPO are covered in full. If you receive a flu shot in another setting, you may be required to pay the full cost of the shot up front. If you are required to pay for the full cost of the flu shot, obtain a receipt and send a copy to us asking us to pay you back for our share of the cost. We will reimburse you the Medicare-approved amount. You will be responsible for paying the difference between the provider's charge and the Medicare-approved amount. For more information on your coverage for immunizations, see the *Medical Benefits Chart* appendix.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 7 of this document (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has information about how to make an appeal.

SECTION 2 How to ask us to pay you back or to pay a bill you have received

You may request us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records. You must submit your claim to us within 12 months of the date you received the service, item, or drug.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it will help us process the information faster. Please include your name, member number from your identification card, address, phone number and a copy of an itemized receipt.
- Either download a copy of the form from our website (medicare.highmark.com) or call Member Service and ask for the form.

Mail your request for payment together with any bills or receipts to us at this address:

P.O. Box 1068
Pittsburgh, PA 15230-1068

SECTION 3 We will consider your request for payment and say yes or no

Section 3.1 We check to see whether we should cover the service and how much we owe

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the medical care is covered and you followed all the rules, we will pay for our share of the cost. If you have already paid for the service, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service yet, we will mail the payment directly to the provider.
- If we decide that the medical care is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. We will send you a letter explaining the reasons why we are not sending the payment and your right to appeal that decision.

Section 3.2 If we tell you that we will not pay for all or part of the medical care, you can make an appeal

If you think we have made a mistake in turning down your request for payment or the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For details on how to make this appeal, go to Chapter 7 of this document.

CHAPTER 6:

Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities as a member of the plan

Section 1.1 We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, in large print or other alternate formats, etc.)

Your plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how a plan may meet these accessibility requirements include, but are not limited to provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in braille, in large print or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Service.

Our plan is required to give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services.

If providers in the plan's network for a specialty are not available, it is the plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care and you will have the same level of benefits as using a network provider. If you find yourself in a situation where there are no specialists in the plan's network that cover a service you need, call the plan for information on where to go to obtain this service at in-network cost sharing.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Member Service at 1-888-328-2960. You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

Section 1.2 We must ensure that you get timely access to your covered services

You have the right to choose a provider in the plan's network.

You have the right to get appointments and covered services from your providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care.

If you think that you are not getting your medical care within a reasonable amount of time, Chapter 7, Section 9 of this document tells what you can do.

Section 1.3 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- You have rights related to your information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practice," that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you or someone you have given legal power to make decisions for you first*.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
    - We are required to release health information to government agencies that are checking on quality of care.
    - Because you are a member of our plan through Medicare, we are required to give Medicare your health information. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held by the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Member Service.

We are committed to protecting your privacy and personal health information (PHI). This includes PHI discussed verbally. Some of the ways we protect your privacy includes not discussing PHI outside of our offices, as well as verifying your identity before we discuss PHI with you over the phone. You can also read our Notice of Privacy Practices (NPP) on our website. Log onto medicare.highmark.com and click on "Privacy Policy and Notice of Privacy Practices" at the bottom of the

page. To download a copy, click on "Highmark Inc. NPP". You can also call Member Service at the number listed on your ID card to request a copy of our NPP.

Section 1.4 We must give you information about the plan, its network of providers, your covered services, and your member rights and responsibilities

As a member of Freedom Blue PPO, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call Member Service:

- **Information about our plan**. This includes, for example, information about the plan's financial condition.
- **Information about our network providers.** You have the right to get information about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
- **Information about your coverage and the rules you must follow when using your** coverage. Chapters 3 and 4 provide information regarding medical services.
- **Information about why something is not covered and what you can do about** it. Chapter 7 provides information on asking for a written explanation on why a medical service is not covered or if your coverage is restricted. Chapter 9 also provides information on asking us to change a decision, also called an appeal.

Section 1.5 We must support your right to make decisions about your care

You have the right to know your treatment options and participate in decisions about your health care

You have the right to get full information from your doctors and other health care providers. Your providers must explain your medical condition and your treatment choices *in a way that you can understand*.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** You have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no.**" You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. Of course, if you refuse treatment, you accept full responsibility for what happens to your body as a result.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance of these situations are called "**advance directives**." There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.

If you want to use an "advance directive" to give your instructions, here is what to do:

- **Get the form.** You can get an advance directive form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital**.

- The hospital will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with your State Department of Heath.

State	Physician	Hospital
Delaware	Division of Professional Regulation	Division of Professional Regulation

	Cannon Building, Suite 203 861 Silver Lake Blvd. Dover, Delaware 19904 1-302-744-4500 dpr.delaware.gov	Cannon Building, Suite 203 861 Silver Lake Blvd. Dover, Delaware 19904 1-302-744-4500 dpr.delaware.gov
New York	Office of Professional Medical Conduct Central Intake Unit Riverview Center 150 Broadway- Suite 355 Albany, NY 12204-2719 1-800-663-6114 www.health.ny.gov/professionals/doctors/conduct/	New York State Department of Health Centralized Hospital Intake Program Mailstop: CA/DCS Empire State Plaza Albany, NY 12237 1-800-804-5447 apps.health.ny.gov/surveyd8/facility-complaint-form
Pennsylvania	Department of State Bureau of Professional and Occupational Affairs Compliance Office P.O. Box 2649 Harrisburg, PA 17105 717-787-8503 www.dos.pa.gov/Pages/File-a-Complaint.aspx	Pennsylvania Department of Health Division of Acute and Ambulatory Care H&W Building, Room 532 625 Forster Street Harrisburg, PA 17120 1-717-783-8980 apps.health.pa.gov/dohforms/FacilityComplaint.aspx
West Virginia	West Virginia Board of Medicine Attn: Complaints Coordinator 101 Dee Drive, Suite 103 Charleston, West Virginia 25311 1-304-558-2921 ext. 49867 https://wvbom.wv.gov/Instructions_and_Forms.asp	Office of Health Facility Licensure & Certification Attention: [Health Care Facility Type] Complaint Intake 408 Leon Sullivan Way Charleston, WV 25301-1713 1-304-558-005 https://ohflac.wvdhhr.org/complaint.html

Section 1.6 You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems, concerns, or complaints and need to request coverage, or make an appeal, Chapter 7 of this document tells what you can do. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly**.

Section 1.7 What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, sexual orientation, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you are having:

- You can **call Member Service**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

Section 1.8 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can **call Member Service**.
- You can **call the State Health Insurance Assistance Program**. For details, go to Chapter 2, Section 3.
- You can contact **Medicare**.
  - You can visit the Medicare website to read or download the publication "Medicare Rights & Protections." (The publication is available at: www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
  - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

SECTION 2 You have some responsibilities as a member of the plan

Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Service.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* to learn what is covered for you and the rules you need to follow to get your covered services.
  - Chapters 3 and 4 give the details about your medical services.
- **If you have any other health insurance coverage in addition to our plan, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - You must continue to pay your Medicare Part B to remain a member of the plan.
  - For most of your medical services covered by the plan, you must pay your share of the cost when you get the service.
- **If you move *within* our service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* of the United States or its territories, you cannot remain a member of our plan.**
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

CHAPTER 7:

What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

CHAPTER 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

This chapter explains two types of processes for handling problems and concerns:

- For some problems, you need to use the **process for coverage decisions and appeals**.
- For other problems, you need to use the **process for making complaints;** also called grievances.

Both of these processes have been approved by Medicare. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

The guide in Section 3 will help you identify the right process to use and what you should do.

Section 1.2 What about the legal terms?

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand. To make things easier, this chapter:

- Uses simpler words in place of certain legal terms. For example, this chapter generally says "making a complaint" rather than "filing a grievance," "coverage decision" rather than "organization determination," or "coverage determination" or "at-risk determination," and "independent review organization" instead of "Independent Review Entity."
- It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms. Knowing which terms to use will help you communicate more accurately to get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 Where to get more information and personalized assistance

We are always available to help you. Even if you have a complaint about our treatment of you, we are obligated to honor your right to complain. Therefore, you should always reach out to Member Service for help. But in some situations, you may also want help or guidance from someone who is not connected with us. Below are two entities that can assist you.

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers and website URLs in Chapter 2, Section 3 of this document.

Medicare

You can also contact Medicare to get help. To contact Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can also visit the Medicare website (www.medicare.gov).

SECTION 3 To deal with your problem, which process should you use?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

Is your problem or concern about your benefits or coverage?

This includes problems about whether medical care or prescription drugs are covered or not, the way they are covered, and problems related to payment for medical care or prescription drugs.

Yes.

Go on to the next section of this chapter, **Section 4, "A guide to the basics of coverage decisions and appeals."**

No.

Skip ahead to **Section 9** at the end of this chapter: **"How to make a complaint about quality of care, waiting times, customer service or other concerns."**

COVERAGE DECISIONS AND APPEALS

SECTION 4 A guide to the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals: the big picture

Coverage decisions and appeals deal with problems related to your benefits and coverage for medical services, including payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions prior to receiving services

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide a service is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after a service is received, and you are not satisfied, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, which we discuss later, you can request an expedited or "fast appeal" of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we were properly following the rules. When we have completed the review, we give you our decision. In limited circumstances a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we do not dismiss your case but say no to all or part of your Level 1 appeal, you can go on to a Level 2 appeal. The Level 2 appeal is conducted by an independent review organization that is not connected to us. (Appeals for medical services and Part B drugs will be automatically sent to the independent review organization for a Level 2 appeal – you do not need to do anything. If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (Section 8 in this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Member Service**.
- You **can get free help** from your State Health Insurance Assistance Program.
- **Your doctor can make a request for you. I**f your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Please call Member Service and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at medicare.highmark.com.)
    - For medical care or Part B prescription drugs, your doctor can request a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
    - If you want a friend, relative, or other person to be your representative, call Member Service and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at medicare.highmark.com). The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
    - While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.3 Which section of this chapter gives the details for your situation?

There are three different situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 5** of this chapter: "Your medical care: How to ask for a coverage decision or make an appeal"
- **Section 6** of this chapter: "How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon"
- **Section 7** of this chapter: "How to ask us to keep covering certain medical services if you think your coverage is ending too soon" (*Applies only to these services*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which section you should be using, please call Member Service. You can also get help or information from government organizations such as your State Health Insurance Assistance Program.

SECTION 5 Your medical care: How to ask for a coverage decision or make an appeal of a coverage decision

Section 5.1 This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care

This section is about your benefits for medical care and services. These benefits are described in the *Medical Benefits Chart* appendix. To keep things simple, we generally refer to "medical care coverage" or "medical care" which includes medical items and services as well as Medicare Part B prescription drugs. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

This section tells what you can do if you are in any of the five following situations:

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**
2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan. **Ask for a coverage decision. Section 5.2.**
3. You have received medical care that you believe should be covered by the plan, but we have said we will not pay for this care. **Make an Appeal. Section 5.3.**
4. You have received and paid for medical care that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5.**
5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an Appeal. Section 5.3.**

Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read Sections 6 and 7 of this Chapter. Special rules apply to these types of care.

CHAPTER 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Section 5.2 Step-by-step: How to ask for a coverage decision

Legal Terms
When a coverage decision involves your medical care, it is called an **"organization determination."** A "fast coverage decision" is called an **"expedited determination."**

Step 1: Decide if you need a "standard coverage decision" or a "fast coverage decision."

A "standard coverage decision" is usually made within 14 days or 72 hours for Part B drugs. A "fast coverage decision" is generally made within 72 hours, for medical services, 24 hours for Part B drugs. In order to get a fast coverage decision, you must meet two requirements:

- You may *only ask* for coverage for medical care *you have not yet received.*
- You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
  - Explains that we will use the standard deadlines.
  - Explains if your doctor asks for the fast coverage decision, we will automatically give you a fast coverage decision.
  - Explains that you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested.

Step 2: Ask our plan to make a coverage decision or fast coverage decision.

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this. Chapter 2 has contact information.

Step 3: We consider your request for medical care coverage and give you our answer.

For standard coverage decisions we use the standard deadlines

This means we will give you an answer within 14 calendar days after we receive your request **for a medical item or service.** If your request is for a **Medicare Part B prescription drug,** we will give you an answer **within 72 hours** after we receive your request.

- **However,** if you ask for more time, or if we need more information that may benefit you **we can take up to 14 more days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

- If you believe we should *not* take extra days, you can file a "fast complaint". We will give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. See Section 9 of this chapter for information on complaints.)

For Fast Coverage decisions we use an expedited timeframe

A fast coverage decision means we will answer within 72 hours if your request is for a medical item or service. If your request is for a Medicare Part B prescription drug, we will answer within 24 hours.

- **However,** if you ask for more time, or if we need more that may benefit you **we can take up to 14 more days**. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a "fast complaint". (See Section 9 of this chapter for information on complaints.) We will call you as soon as we make the decision.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Step 4: If we say no to your request for coverage for medical care, you can appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the medical care coverage you want. If you make an appeal, it means you are going on to Level 1 of the appeals process.

Section 5.3 Step-by-step: How to make a Level 1 appeal

Legal Terms

An appeal to the plan about a medical care coverage decision is called a plan **"reconsideration."**

A "fast appeal" is also called an **"expedited reconsideration."**

Step 1: Decide if you need a "standard appeal" or a "fast appeal."

A "standard appeal" is usually made within 30 days. A "fast appeal" is generally made within 72 hours.

- If you are appealing a decision we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a "fast appeal." If your doctor tells us that your health requires a "fast appeal," we will give you a fast appeal.
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 5.2 of this chapter.

Step 2: Ask our plan for an Appeal or a Fast Appeal

- **If you are asking for a standard appeal, submit your standard appeal in writing.**You may also ask for an appeal by calling us. Chapter 2 has contact information.
- **If you are asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.**

Step 3: We consider your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take a careful look at all of the information. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if needed, possibly contacting you or your doctor.

Deadlines for a "fast appeal"

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to.
  - However, if you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time if your request is for a Medicare Part B prescription drug.
  - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it receives your appeal.

Deadlines for a "standard appeal"

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet

received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.

- However, if you ask for more time, or if we need more information that may benefit you, we can take **up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a "fast complaint.". When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)
- If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug.
- **If our plan says no to part or all of your appeal**, we will automatically send your appeal to the independent review organization for a Level 2 appeal.

Section 5.4 Step-by-step: How a Level 2 appeal is done

Legal Terms

The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

The **independent review organization is an independent organization hired by Medicare**. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: The independent review organization reviews your appeal.

- We will send the information about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file.**
- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

If you had a "fast appeal" at Level 1, you will also have a "fast appeal" at Level 2

- For the "fast appeal" the review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it receives your appeal.
- However, if your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

If you had a "standard appeal" at Level 1, you will also have a "standard appeal" at Level 2

- For the "standard appeal" if your request is for a medical item or service, the review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it receives your appeal. If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it receives your appeal.
- However, if your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

Step 2: The independent review organization gives you their answer.

The independent review organization will tell you its decision in writing and explain the reasons for it.

- **If the review organization says yes to part or all of a request for a medical item or service,** we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization for standard requests. For expedited requests, we have 72 hours from the date we receive the decision from the review organization.
- **If the review organization says yes to part or all of a request for a Medicare Part B prescription drug**, we must authorize or provide the Part B prescription drug within **72 hours** after we receive the decision from the review organization for **standard requests**. For **expedited requests** we have **24 hours** from the date we receive the decision from the review organization.
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision" or "turning down your appeal"). In this case, the independent review organization will send you a letter:
  - Explaining its decision.
  - Notifying you of the right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
  - Telling you how to file a Level 3 appeal.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter explains the Level 3, 4, and 5 appeals processes.

Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?

Chapter 5 describes when you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork asking for reimbursement, you are asking for a coverage decision. To make this coverage decision, we will check to see if the medical care you paid for is a covered service. We will also check to see if you followed all the rules for using your coverage for medical care.

- **If we say yes to your request:** If the medical care is covered and you followed all the rules, we will send you the payment for our share of the cost within 60 calendar days after we receive your request. If you haven't paid for the services, we will send the payment directly to the provider.
- **If we say no to your request:** If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why.

If you do not agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in Section 5.3. For appeals concerning reimbursement, please note:

- We must give you our answer within 60 calendar days after we receive your appeal. If you are asking us to pay you back for medical care you have already received and paid for, you are not allowed to ask for a fast appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

SECTION 6 How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about our coverage for your hospital care, including any limitations on this coverage, see the *Medical Benefits Chart* appendix.

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for care you may need after you leave.

- The day you leave the hospital is called your "**discharge date**."
- When your discharge date has been decided, your doctor or the hospital staff will let you know.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This section tells you how to ask.

Section 6.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

Within two days of being admitted to the hospital, you will be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice. If you do not get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, please call Member Service or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you:
   - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
   - Your right to be involved in any decisions about your hospital stay.
   - Where to report any concerns you have about the quality of your hospital care.
   - Your right to **request an immediate review** of the decision to discharge you if you think you are being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time.
2. **You will be asked to sign the written notice to show that you received it and understand your rights.**
   - You or someone who is acting on your behalf will be asked to sign the notice.
   - Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date. Signing the notice **does *not* mean** you are agreeing on a discharge date.

3. **Keep your copy** of the notice handy so you will have the information about making an appeal (or reporting a concern about quality of care) if you need it.
   - If you sign the notice more than two days before your discharge date, you will get another copy before you are scheduled to be discharged.
   - To look at a copy of this notice in advance, you can call Member Service or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

Section 6.2 Step-by-step: How to make a Level 1 appeal to change your hospital discharge date

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are:

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Service. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

The **Quality Improvement Organization** is a group of doctors and other health care professionals who are paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts are not part of our plan.

Step 1: Contact the Quality Improvement Organization for your state and ask for an "immediate" review of your hospital discharge. You must act quickly.

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. Or, find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge.**
  - **If you meet this deadline,** you may stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.

- **If you do *not* meet this deadline,** and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see Section 6.4.

- Once you request an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted, we will give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.
- You can get a sample of the **Detailed Notice of Discharge** by calling Member Service or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

- Health professionals at the Quality Improvement Organization ("the reviewers") will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers told us of your appeal, you will get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the review organization says *yes*, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services.

What happens if the answer is no?

- If the review organization says *no*, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the review organization says *no* to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization has said *no* to your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to "Level 2" of the appeals process.

Section 6.3 Step-by-step: How to make a Level 2 appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at their decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you stay in the hospital after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary**.
- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

- It means they agree with the decision they made on your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.

- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 6.4 What if you miss the deadline for making your Level 1 appeal?

Legal Terms
A "fast review" (or "fast appeal") is also called an **"expedited appeal."**

You can appeal to us instead

As explained above, you must act quickly to start your Level 1 appeal of your hospital discharge. If you miss the deadline for contacting the Quality Improvement Organization, there is another way to make your appeal.

If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* appeal

Step 1: Contact us and ask for a "fast review."

- **Ask for a "fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines. Chapter 2 has contact information.

Step 2: We do a "fast review" of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We see if the decision about when you should leave the hospital was fair and followed all the rules.

Step 3: We give you our decision within 72 hours after you ask for a "fast review".

- **If we say yes to your appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date. We will keep providing your covered inpatient hospital services for as long as they are medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
  - If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

Step 4: If we say *no* to your appeal, your case will *automatically* be sent on to the next level of the appeals process.

Step-by-Step: Level 2 *Alternate* Appeal Process

Legal Terms
The formal name for the "independent review organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

The **independent review organization is an independent organization hired by Medicare.** It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: We will automatically forward your case to the independent review organization.

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 9 of this chapter tells how to make a complaint.)

Step 2: The independent review organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says *yes* to your appeal,** then we must pay you back for our share of the costs of hospital care you received since the date of your planned discharge. We must also continue the plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree that your planned hospital discharge date was medically appropriate.
    - The written notice you get from the independent review organization will tell how to start a Level 3 appeal review process, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 3: If the independent review organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 appeal, you decide whether to accept their decision or go on to Level 3 appeal.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 7.1 *This section is about three services only:* Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

When you are getting **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *we will stop paying our share of the cost for your care*.

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Section 7.2 We will tell you in advance when your coverage will be ending

Legal Terms

"**Notice of Medicare Non-Coverage."** It tells you how you can request a **"fast-track appeal."** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care.

1. **You receive a notice in writing** at least two days before our plan is going to stop covering your care. The notice tells you:
   - The date when we will stop covering the care for you.
   - How to request a "fast track appeal" to request us to keep covering your care for a longer period of time.
2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you received it.** Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with the plan's decision to stop care.

Section 7.3 Step-by-step: How to make a Level 1 appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Service. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate.

The **Quality Improvement Organization** is a group of doctors and other health care experts who are paid by the Federal government to check on and improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts are not part of our plan.

Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a *fast-track appeal*. You must act quickly.

How can you contact this organization?

- The written notice you received (*Notice of Medicare Non-Coverage*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the Notice of Medicare Non-Coverage.

Your deadline for contacting this organization.

- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see Section 7.5.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

Legal Terms
"**Detailed Explanation of Non-Coverage."** Notice that provides details on reasons for ending coverage.

What happens during this review?

- Health professionals at the Quality Improvement Organization ("the reviewers") will ask you, or your representative, why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers tell us of your appeal, you will get the **Detailed Explanation of Non-Coverage** from us that explains in detail our reasons for ending our coverage for your services.

Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.

What happens if the reviewers say yes?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say *no*, then **your coverage will end on the date we have told you.**
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If reviewers say *no* to your Level 1 appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make a Level 2 appeal.

Section 7.4 Step-by-step: How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes?

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision made to your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7.5 What if you miss the deadline for making your Level 1 appeal?

You can appeal to us instead

As explained above, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

Legal Terms
A “fast review” (or “fast appeal”) is also called an **“expedited appeal**.**”**

Step 1: Contact us and ask for a “fast review.”

- **Ask for a “fast review**.” This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines. Chapter 2 has contact information.

Step 2: We do a "fast review" of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan's coverage for services you were receiving.

Step 3: We give you our decision within 72 hours after you ask for a "fast review".

- **If we say yes to your appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your appeal,** then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end, then **you will have to pay the full cost** of this care.

Step 4: If we say *no* to your fast appeal, your case will *automatically* go on to the next level of the appeals process.

Legal Terms
The formal name for the "independent review organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step-by-Step: Level 2 *Alternate* Appeal Process

During the Level 2 appeal, the **independent review organization** reviews the decision we made to your "fast appeal." This organization decides whether the decision should be changed. **The independent review organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the independent review organization. Medicare oversees its work.

Step 1: We automatically forward your case to the independent review organization.

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 9 of this chapter tells how to make a complaint.)

Step 2: The independent review organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

- **If this organization says *yes* to your appeal,** then we must pay you back for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover services.
- **If this organization says *no* to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
- The notice you get from the independent review organization will tell you in writing what you can do if you wish to go on to a Level 3 appeal.

Step 3: If the independent review organization says no to your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- A Level 3 appeal is reviewed by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 Taking your appeal to Level 3 and beyond

Section 8.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

This section may be appropriate for you if you have made a Level 1 appeal and a Level 2 appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 appeal	**An Administrative Law Judge or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may* or *may not* be over.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that is favorable to you. If we decide to appeal, it will go to a Level 4 appeal.
  - If we decide *not* to appeal, we must authorize or provide you with the service within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator's decision.

- If we decide to appeal the decision, we will send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the service in dispute.

- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal	The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may* or *may not* be over.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We will decide whether to appeal this decision to Level 5.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Council's decision.
  - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 appeal and how to continue with Level 5 appeal.

Level 5 appeal	A judge at the **Federal District Court** will review your appeal.

- A judge will review all of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

MAKING COMPLAINTS

SECTION 9 How to make a complaint about quality of care, waiting times, customer service, or other concerns

If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.

CHAPTER 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Section 9.1 What kinds of problems are handled by the complaint process?

The complaint process is *only* used for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Member Service? • Do you feel you are being encouraged to leave the plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors or other health professionals? Or by our Member Service or other staff at the plan? ◦ Examples include waiting too long on the phone, in the waiting or exam room
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)	If you already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a "fast coverage decision" or a "fast appeal," and we have said no; you can make a complaint. • You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we are not meeting deadlines for covering or reimbursing you for certain medical services that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

CHAPTER 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Section 9.2 How to make a complaint

Legal Terms

- A **"Complaint"** is also called a **"grievance."**
- **"Making a complaint"** is also called **"filing a grievance."**
- "**Using the process for complaints"** is also called "**using the process for filing a grievance."**
- A **"fast complaint"** is also called an **"expedited grievance."**

Section 9.3 Step-by-step: Making a complaint

Step 1: Contact us promptly – either by phone or in writing.

- **Usually, calling Member Service is the first step.** If there is anything else you need to do, Member Service will let you know.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
  - **The Standard Grievance Procedure is as follows:**

  Your initial inquiry should be directed to the Member Service department. If you are dissatisfied with the response to your inquiry, you can ask for a Complaint Review. Your request for a Complaint Review can be made orally or in writing and may include written information from you or any other party of interest. Send your written complaint to:

  Appeals and Grievance Dept.
  P.O. Box 535047
  Pittsburgh, PA 15253-5047

  We will review your written complaint. For complaints regarding such issues as waiting times, physician or pharmacy staff behavior and demeanor, quality of care, adequacy of or access to facilities, fraud or abuse concerns, and other similar member concerns, we will take the appropriate steps to investigate your complaint. These steps may include, but are not limited to, investigating with the provider, a review of the medical records or ongoing provider monitoring. We will respond in writing within 30 days or as expeditiously as the case requires. Decisions made during the Complaint Review Process are final and binding.

  The Expedited or "Fast Grievance" Procedure is as follows:

  The expedited grievance procedure is used in the following instances:

  - If you disagree with Highmark BCBSD, INC. invoking a 14-day extension on either an initial determination or a reconsideration.
  - If you disagree with the decision not to grant you an expedited initial determination or reconsideration.

Your initial inquiry should be directed to the Member Service department. You may call the number on your member ID card, Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time. Outside these hours, please call 1-888-328-2960 (TTY users, call 711).

You may file this request either orally or in writing. Your complaint may include information from you or any other party of interest. Highmark BCBSD, INC. will review your complaint and take the appropriate steps to investigate your complaint. Highmark BCBSD, INC. will respond in writing within 24 hours from the date the Grievance department receives your complaint.

- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast complaint."** If you have a "fast complaint," it means we will give you **an answer within 24 hours**.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will include our reasons in our response to you.

Section 9.4 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint directly to the Quality Improvement Organization**. The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time.**

Section 9.5 You can also tell Medicare about your complaint

You can submit a complaint about Freedom Blue PPO directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 8:

Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

Ending your membership in Freedom Blue PPO may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you want to leave. Sections 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, our plan must continue to provide your medical care and you will continue to pay your cost share until your membership ends.

SECTION 2 When can you end your membership in our plan?

Section 2.1 You can end your membership during the Annual Enrollment Period

You can end your membership in our plan during the **Annual Enrollment Period** (also known as the "Annual Open Enrollment Period"). During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- **Review your State of Delaware open enrollment information.**
- **The Centers for Medicare and Medicaid (CMS) Annual Enrollment Period** is from **October 15 to December 7**.
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to cancel your coverage through your former employer and change to a new plan, you can choose any of the following types of plans:
  - Another Medicare health plan, with or without prescription drug coverage.
  - Original Medicare *with* a separate Medicare prescription drug plan.

  OR

  - Original Medicare *without* a separate Medicare prescription drug plan.
- Your membership will end when your new plan's coverage begins on January 1.

Section 2.2 You can end your membership during the Medicare Advantage Open Enrollment Period

You have the opportunity to make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period**.

- **The annual Medicare Advantage Open Enrollment Period** is from January 1 to March 31.

- **During the annual Medicare Advantage Open Enrollment Period** you can:
  - Switch to another Medicare Advantage Plan with or without prescription drug coverage.
  - Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of Freedom Blue PPO may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply to you. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (www.medicare.gov):

- Usually, when you have moved.
- If you have Medicaid.
- If we violate our contract with you.
- If you get care in an institution, such as a nursing home or long-term care (LTC) hospital.
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE).

The enrollment time periods vary depending on your situation.

To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:

- Another Medicare health plan with or without prescription drug coverage.
- Original Medicare *with* a separate Medicare prescription drug plan.

OR

- Original Medicare *without* a separate Medicare prescription drug plan.

- **When will your membership end?** Your membership will usually end on the first day of the month after your request to change your plan is received.

Section 2.4 Where can you get more information about when you can end your membership?

If you have any questions about ending your membership you can:

- **Call Member Service**
- You can find the information in the ***Medicare & You 2023*** handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

SECTION 3 How do you end your membership in our plan?

The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	This is what you should do:
• Another Medicare health plan.	• Enroll in the new Medicare health plan. • You will automatically be disenrolled from Freedom Blue PPO when your new plan's coverage begins.
• Original Medicare *with* a separate Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan. • You will automatically be disenrolled from Freedom Blue PPO when your new plan's coverage begins.
• Original Medicare *without* a separate Medicare prescription drug plan.	• **Send us a written request to disenroll.** Contact Member Service if you need more information on how to do this. • You can also contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from Freedom Blue PPO when your coverage in Original Medicare begins.

Note: If you also have creditable prescription drug coverage (e.g., standalone PDP) and disenroll from that coverage, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later after going without creditable prescription drug coverage for 63 days or more in a row.

SECTION 4 Until your membership ends, you must keep getting your medical services through our plan

Until your membership ends, and your new Medicare coverage begins, you must continue to get your medical care through our plan.

- **If you are hospitalized on the day that your membership ends, your hospital stay will be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 Freedom Blue PPO must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

Freedom Blue PPO must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.
- If you move out of the United States.
- If you are away from the United States or its territories for more than twelve months.
- If you become incarcerated (go to prison).
- If you are no longer a United States citizen or lawfully present in the United States.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

Where can you get more information?

If you have questions or would like more information on when we can end your membership call Member Service.

Section 5.2 We cannot ask you to leave our plan for any health-related reason

Freedom Blue PPO is not allowed to ask you to leave our plan for any health related reason.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

CHAPTER 9:
Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws are not included or explained in this document.

SECTION 2 Notice about non-discrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at www.hhs.gov/ocr/index.

If you have a disability and need help with access to care, please call us at Member Service. If you have a complaint, such as a problem with wheelchair access, Member Service can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Freedom Blue PPO, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

NOTICE OF MEDICARE SECONDARY PAYER SUBROGATION RIGHTS

As a Medicare Advantage Plan that provides your federal Medicare benefits, this Plan has the right and responsibility to recover for covered Medicare services for which Medicare is not the primary payer. This means that the benefits provided under this Plan are secondary to any other sources of payment including but not limited to uninsured and underinsured motorist coverage, any no-fault insurance, medical payments coverage (auto, homeowners or otherwise), individual or group health

insurance, workers compensation, any other insurance or any individual or other liable party(including companies, corporations or other entities).

This Medicare Advantage Plan conditionally provides payments until another source is identified, available and determined to be responsible for payment, whether through settlement, judgment, arbitration award or verdict. A Medicare Advantage Plan, pursuant to 42 C.F.R §422.108 and 423.462, has the same rights of recovery exercised by traditional Medicare through Federal Law and supersedes any State law. In addition to the rights granted under Federal law, this Plan asserts contractual rights of recovery through subrogation and reimbursement.

Reimbursement

This section applies when a Covered Person, or the legal representative, estate or heirs of the Covered Person (sometimes collectively referred to as the "Covered Person") recovers damages, by settlement, verdict or otherwise (including wrongful death and/or survivorship cases) for an injury, sickness or other condition. If the Covered Person has made, or in the future may make, such a recovery, including a recovery from any insurance carrier, the Plan will not cover either the reasonable value of the services to treat such an injury or illness or the treatment of such an injury or illness. These benefits are specifically excluded.

However, if the Plan does advance moneys or provide care for such an injury, sickness or other condition, the Covered Person shall promptly convey moneys or other property from any settlement, arbitration award, verdict or any insurance proceeds or monetary recovery from any party received by the Covered Person (or by the legal representatives, estate or heirs of the Covered Person), to the Plan for the reasonable value of the medical benefits advanced or provided by the Plan to the Covered Person, regardless of whether or not (1) the Covered Person has been fully compensated, or "made-whole" for his/her loss; (2) liability for payment is admitted by the Covered Person or any other party; or (3) the recovery by the Covered Person is itemized or called anything other than a recovery for medical expenses incurred.

If a recovery is made, the Plan shall have first priority in payment over the Covered Person, or any other party, to receive reimbursement of the benefits advanced on the Covered Person's behalf. This reimbursement shall be from any recovery made by the Covered Person, and includes, but is not limited to, uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation settlement, compromises or awards, other group insurance (including student plans), and direct recoveries from liable parties. Likewise, the reimbursement provision specifically applies to recoveries obtained from wrongful death and/or survivorship cases. The Plan's first priority right shall apply to all recoveries whether or not the amount constitutes a full or partial recovery of the Covered Person's damages.

In order to secure the rights of the Plan under this section, and because of the Plan's advancement of benefits, the Covered Person hereby (1) acknowledges that the Plan shall have a first priority lien against the proceeds of any such settlement, arbitration award, verdict, or any other amounts received by the Covered Person; and (2) assigns to the Plan any benefits the Covered Person may have under any automobile policy or other coverage, to the extent of the Plan's claim for reimbursement. The Covered Person shall sign and deliver, at the request of the Plan or its agents,

any documents needed to protect such priority or reimbursement right, or to effect such assignment of benefits. By accepting any benefits advanced by the Plan under this section, the Covered Person acknowledges that any proceeds of settlement or judgment, including a Covered Person's claim to such proceeds held by another person, held by the Covered Person or by another, are being held for the benefit of the Plan under these provisions. The Covered Person agrees that the proceeds subject to the plan's lien are Plan assets and that the Covered Person will hold such assets as a trustee for the Plan's benefit and shall remit to the Plan, or its representative, such assets upon request. If represented by counsel, the Covered Person agrees to direct such counsel to hold the proceeds subject to the Plan's lien in trust and to remit such funds to the Plan, or its representative, upon request. Should the Covered Person violate any portion of this section, the Plan shall have a right to offset future benefits otherwise payable under this plan to the extent of the value of the benefits advanced under this section to the extent not recovered by the plan. The Plan may also seek double damages in a private action.

The Covered Person shall cooperate with the Plan and its agents, and shall sign and deliver such documents as the Plan or its agents reasonably request to protect the Plan's right of reimbursement, provide any relevant information, and take such actions as the Plan or its agents reasonably request to assist the Plan making a full recovery of the reasonable value of the benefits provided. The Covered Person shall not take any action that prejudices the Plan's rights of reimbursement and consents to the right of the Plan, by and through its agent, to impress an equitable lien or constructive trust on the proceeds of any settlement to enforce the Plan's rights under this section, and/or to set off from any future benefits otherwise payable under the Plan the value of benefits advanced under this section to the extent not recovered by the Plan.

The Plan shall be responsible only for those legal fees and expenses to which it agrees in writing. No Covered Person hereunder shall incur any expenses on behalf of the Plan in pursuit of the Plan's rights hereunder. Specifically, no court costs or attorney's fees may be deducted from the Plan's recovery without the express written consent of the Plan. Any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right.

In cases of occupational illness or injury, the Plan's recovery rights shall apply to all sums recovered, regardless of whether the illness or injury is deemed compensable under any workers' compensation or other coverage. Any award or compromise settlement, including any lump-sum settlement, shall be deemed to include the Plan's interest and the Plan shall be reimbursed in first priority from any such award or settlement.

The Plan shall recover the full amount of benefits advanced and paid hereunder, without regard to any claim or fault on the part of any beneficiary of Covered Person, whether under comparative negligence or otherwise.

Subrogation

This section applies when another party is, or may be considered, liable for a Covered Person's injury, sickness or other condition (including insurance carriers who are so financially liable) and the Plan has advanced benefits.

In consideration for the advancement of benefits, the Plan is subrogated to all of the rights of the Covered Person against any party liable for the Covered Person's injury or illness, or is or may be liable for the payment for the medical treatment of such injury or occupational illness (including any insurance carrier), to the extent of the value of the medical benefits advanced to the Covered Person under the Plan. The Plan may assert this right independently of the Covered Person. This right includes, but is not limited to, the Covered Person's rights under uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, or other insurance, as well as the Covered Person's rights under the Plan to bring an action to clarify his or her rights under the Plan. The Plan is not obligated in any way to pursue this right independently or on behalf of the Covered Person, but may choose to pursue its rights to reimbursement under the Plan, at its sole discretion.

The Covered Person is obligated to cooperate with the Plan and its agents in order to protect the Plan's subrogation rights. Cooperation means providing the Plan or its agents with any relevant information requested by them, signing and delivering such documents as the Plan or its agents reasonably request to secure the Plan's subrogation claim, and obtaining the consent of the Plan or its agents before releasing any party from liability for payment of medical expenses.

If the Covered Person enters into litigation or settlement negotiations regarding the obligations of other parties, the Covered Person must not prejudice, in any way, the subrogation rights of the Plan under this section. In the event that the Covered Person fails to cooperate with this provision, including executing any documents required herein, the Plan may, in addition to remedies provided elsewhere in the Plan and/or under the law, set off from any future benefits otherwise payable under the Plan the value of benefits advanced under this section to the extent not recovered by the Plan.

The Plan's subrogation right is a first priority right and must be satisfied in full prior to any other claim of the Covered Person or his/her representative(s), regardless of whether the Covered Person is fully compensated for his/her damages. The costs of legal representation of the Plan in matters related to subrogation shall be borne solely by the Plan. The costs of legal representation of the Covered Person shall be borne solely by the Covered Person.

SECTION 4 Notice about how we determine if a technology is experimental

Medical experts are constantly searching for and testing new equipment and methods for treating health conditions. In turn, health care plans like Highmark BCBSD, INC. must evaluate these technologies to determine if they are covered by your Freedom Blue PPO plan.

Highmark BCBSD, INC. believes that decisions for evaluating new technologies, new applications of existing technologies and devices should be made by medical professionals. But Highmark BCBSD, INC. also honors decisions made by regulatory bodies, such as the Centers for Medicare & Medicaid Services (CMS). For Medicare Advantage plans like Freedom Blue PPO, CMS requires health plans to follow National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). Sometimes NCDs or LCDs disagree with the health plan's decision. If the

service is being provided to a Medicare Advantage member, the health plan must abide by the regulations and guidance of the NCDs or LCDs.

To stay current and patient-responsive, these reviews are ongoing and all encompassing. They consider factors such as product efficiency, safety and effectiveness. If the technology passes the review process, the Medical Affairs Committee recommends that it be considered an acceptable medical practice and a covered benefit. Technology that does not pass the review is usually considered "experimental/investigative" and not covered by the health plan. However, it may be re-evaluated in the future.

We recognize that situations may occur when you choose to pursue experimental or investigative treatment. If you are concerned that a service you will receive may be considered experimental or investigational, you, the hospital and/or the professional provider may contact Highmark BCBSD, INC. to determine if the service will be covered.

SECTION 5 Notice about how we determine if a drug is experimental

A process similar to the one outlined above is followed for evaluating new drugs. The Pharmacy and Therapeutics (P & T) Committee assesses new drugs based on national and international data, research that is currently underway and expert opinion from leading clinicians. The P & T Committee consists of at least one Highmark BCBSD, INC. employed pharmacist and/or medical director, five board-certified, actively practicing network physicians and two licensed, registered pharmacists currently providing clinical pharmacy services within the Highmark BCBSD, INC. service area. At the committee's discretion, advice, support and consultation may also be sought from physician subcommittees in the following specialties: cardiology, dermatology, endocrinology, hematology/oncology, obstetrics/gynecology, ophthalmology, psychiatry, infectious disease, neurology, gastroenterology and urology. Issues that are addressed during the review process include clinical efficacy, unique value, safety, patient compliance, local physician and specialist input, and pharmacoeconomic impact. After the review is complete, the P & T Committee makes recommendations.

SECTION 6 Notice about what you need to know about your coverage

Have you ever wondered why your health care benefits pay for certain medical services but may not cover other care? Highmark BCBSD, INC. looks at two important things:

- **Your specific benefit plan and what it covers.** You can find out more about what's covered under your benefits by referring to this *Evidence of Coverage*.

- **Whether the specific procedure, therapy, medication or equipment is "medically necessary."** Highmark BCBSD, INC. and the companies that work with us determine if something is "medically necessary" by using nationally recognized guidelines, our own medical policy, Medicare guidelines and specific government guidelines that may apply. The outside companies we work with specialize in certain areas, such as radiology or prescription drugs. All of these companies must meet certain standards, follow Highmark BCBSD, INC. policy, and agree to allow us to review their work every year.

By using this approach to provide coverage, we ensure that all members receive medically appropriate health care and are treated consistently.

No Rewards For Denying Coverage

Highmark BCBSD, INC. does not reward employees, doctors, other health care providers or anyone for denying coverage. We also don't give rewards to anyone who is reviewing care—or making decisions about what's covered—to encourage them to deny coverage.

Who Reviews Requests?

If you or your doctor requests a service that needs to be approved, this request goes to a nurse in our Medical Management & Policy Department. If the nurse cannot approve the request, it is forwarded to a Highmark BCBSD, INC. physician for review. The physician may contact your physician to discuss the request and get more information. After all the medical information has been reviewed, a decision is made.

Need More Information?

Both you and your physician have the right to know the source of the criteria that we use to make decisions about what is covered and what isn't.

- Your physician may request this information by calling 1-800-452-8507 for medical or surgical decisions, and 1-800-258-9808 for a behavioral health decision.

You may also request information about your coverage or benefits by calling Member Service.

SECTION 7 Notice about coordination of benefits

If you are covered under another insurance carrier's program in addition to Freedom Blue PPO, duplicate coverage exists. If you have duplicate coverage, it must be determined which insurance company has primary liability – that is, which coverage will pay first for your eligible health care services. The process of determining this is called "coordination of benefits."

If you are age 65 and older and you have coverage under an employer group plan, based on your current employment or that of your spouse, you must use the benefits of that plan first. Similarly, if you have Medicare based on disability and are covered under an employer plan, either through your own current employment or that of a family member, you must use the benefits of that plan first. In both cases, you will receive only those Freedom Blue PPO benefits that are not covered by the employer group plan.

CHAPTER 10:

Definitions of important words

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Annual Enrollment Period – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or payment for services you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost sharing amount. As a member of Freedom Blue PPO, you only have to pay our plan's cost sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" or otherwise charge you more than the amount of cost sharing your plan says you must pay.

Benefit Period – The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you have not received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare.

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services.

Combined Maximum Out-of-Pocket Amount – This is the most you will pay in a year for all Part A and Part B services from both network (preferred) providers and out-of-network (non-preferred) providers. See Chapter 4, Section 1.2 for information about your combined maximum out-of-pocket amount.

Complaint – The formal name for "making a complaint" is "filing a grievance." The complaint process is used *only* for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment (or "copay") – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription. A copayment is a set amount (for example $10), rather than a percentage.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services are received. Cost sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services are covered; (2) any fixed "copayment" amount that a plan requires when a specific service is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a service, that a plan requires when a specific service is received.

Covered Services – The term we use in this EOC to mean all of the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care provided by people who do not have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Deductible – The amount you must pay for health care before our plan pays.

Disenroll or **Disenrollment** – The process of ending your membership in our plan.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include: walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care – Covered services that are: 1) provided by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Extra Help – A Medicare or a State program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Grievance – A type of complaint you make about our plan or providers including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Home Health Aide – A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an "outpatient."

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

In-Network Maximum Out-of-Pocket Amount – The most you will pay for covered Part A and Part B services received from network (preferred) providers. After you have reached this limit, you will not have to pay anything when you get covered services from network providers for the rest of the contract year. However, until you reach your combined out-of-pocket amount, you must continue to pay your share of the costs when you seek care from an out-of-network (non-preferred) provider. In addition to the maximum out-of-pocket amount for in-network covered Part A and Part B medical services, your plan may also have a maximum out-of-pocket amount for certain types of services.

Low Income Subsidy (LIS) – See "Extra Help."

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Open Enrollment Period – The time period from January 1 until March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan, or obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription

drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after an individual is first eligible for Medicare.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an i) HMO, ii) PPO, a iii) Private Fee-for-Service (PFFS) plan, or a iv) Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Freedom Blue PPO does not offer Medicare prescription drug coverage.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all of the services that are covered by Medicare Part A and B. The term Medicare-Covered Services does not include the extra benefits, such as vision, dental or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

"Medigap" (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or "Plan Member") – A person with Medicare who is eligible to get covered services, who has enrolled in our plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Service – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

Network Provider – "Provider" is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. "**Network providers**" have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called "plan providers."

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called "coverage decisions" in this document.

Original Medicare ("Traditional Medicare" or "Fee-for-service" Medicare) – Original Medicare is offered by the government, and not a private health plan such as Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors,

hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that does not have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan.

Out-of-Pocket Costs – See the definition for "cost sharing" above. A member's cost sharing requirement to pay for a portion of services received is also referred to as the member's "out-of-pocket" cost requirement.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care (LTC) services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

Part C – see "Medicare Advantage (MA) Plan."

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Primary Care Provider (PCP) – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization – Approval in advance to get covered services. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other network provider gets "prior authorization" from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. However, you may want to check with the plan before obtaining services from out-of-network providers to confirm that the service is covered by your plan and what your cost sharing responsibility is. Covered services that need prior authorization are marked in the *Medical Benefits Chart* appendix.

Prosthetics and Orthotics – Medical devices including, but are not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan must disenroll you if you permanently move out of the plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you move into a nursing home, or if we violate our contract with you.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Services – Covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.

Discrimination is Against the Law

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。

请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

Geb Acht: Wann du Deitsch schwetzscht, kannscht du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kannscht du die Nummer an deinre ID Kard dahinner uffrufe (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

ધ્યાન આપશોઃ જો તમે ગુજરાતી ભાષા બોલતા હો, તો ભાષા સહાયતા સેવાઓ, મફતમાં તમને ઉપલબ્ધ છે. તમારા ઓળખપત્રના પાછળના ભાગે આવેલા નંબર પર ફોન કરો (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATTENTION: Si c'est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vous-même. Composez le numéro qui est au dos de votre carte d'identité. (TTY: 711).

ប្រការចាំបាច់ ៖ បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដែលអាចផ្តល់ជូនលោកអ្នក ដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅលេខដែលមាននៅលើខ្នងកាតសម្គាល់របស់របស់លោកអ្នក (TTY: 711)។

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

注：日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください (TTY: 711)。

توجه : اگر شما به زبان **فارسی** صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

BAA ÁKONÍNÍZIN: Diné k'ehgo yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. ID bee nééhózingo nanitinígíí bine'dęę' (TTY: 711) jį' hodíilnih.

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Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield Delaware is an independent licensee of the Blue Cross Blue Shield Association. All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration.

SilverSneakers is a registered mark of Tivity Health Inc. Tivity Health Inc., is a separate company that administers the SilverSneakers program.

Freedom Blue PPO Member Service

Method	Contact Information
CALL	1-888-328-2960 Calls to this number are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time. Member Service also has free language interpreter services available for non-English speakers.
TTY	711 National Relay Service This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time.
FAX	1-717-635-4235
WRITE	P.O. Box 1068 Pittsburgh, PA 15230-1068
WEBSITE	medicare.highmark.com

State Health Insurance Assistance Program

SHIP is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Your state-specific SHIP can be found in the *Agency Contact Information* appendix in this document.

HIGHMARK® DELAWARE

Freedom Blue PPO sponsored by State of Delaware

Highmark BCBSD Inc. is a Medicare Advantage plan with a Medicare contract. Enrollment in Highmark BCBSD Inc. depends on contract renewal.

Medical Benefits Chart

The *Medical Benefits Chart* on the following pages lists the services Freedom Blue PPO covers and what you pay out-of-pocket for each service. The services listed in the *Medical Benefits Chart* are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, equipment, and Part B prescription drugs) *must* be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- Some of the services listed in the *Medical Benefits Chart* are covered as in-network services *only* if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from Freedom Blue PPO.
  - Covered services that need approval in advance to be covered as in-network services are marked by an asterisk (*) in the *Medical Benefits Chart*.
  - You never need approval in advance for out-of-network services from out-of-network providers.
- While you don't need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.

Other important things to know about our coverage:

- For benefits where your cost sharing is a coinsurance percentage, the amount you pay depends on what type of provider you receive the services from:
  - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
  - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
  - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a $0 copayment will apply for the care received for the existing medical condition.
- If Medicare adds coverage for any new services during 2023, either Medicare or our plan will cover those services.

Medical Benefits Chart

 **You will see this apple next to the preventive services in the benefits chart.**

✓ You will see this symbol next to a service that does not apply to the Out-of-Pocket Maximum.

	In-Network	Out-of-Network
Plan Deductible	None	
Plan Coinsurance	0%	See Benefit detail below for out-of-network coinsurance
Combined Out-of-Pocket Maximum	$1,000 Includes all Part A and Part B services and the Outpatient Professional services outside of the U.S. Excludes Private Duty Nursing.	

Services that are covered for you	What you must pay when you get these services
 **Abdominal aortic aneurysm screening** A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, disease, etc.);	**In-Network:** $0 copay per visit **Out-of-Network:** $0 copay per visit

Services that are covered for you	What you must pay when you get these services
• not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.	

Services that are covered for you	What you must pay when you get these services
Ambulance services*	
• Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. • Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. To meet this definition, the member's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. Non-emergency transportation by ambulance is appropriate if either: the member is bed-confined, and it is documented that the member's condition is such that other methods of transportation are contraindicated; or, if the member's medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required. <u>Prior Authorization Requirements</u> All non-emergency transportation by ambulance must be prior authorized (approved in advance) by a plan or a delegate of the plan. The member's non-emergent ambulance provider is responsible for obtaining prior authorization. Any non-emergency transportation services not prior authorized will not be covered.	**In-Network:** 0% coinsurance per one way trip for emergency and non-emergency ambulance services **Out-of-Network:** 0% coinsurance per one way trip for emergency ambulance services 0% coinsurance per one way trip for non-emergency ambulance services *Non-emergency ambulance or other transportation services outside the United States back to the plan service area are not covered. Non-emergency ambulance services require a Physician Certification Statement (PCS).* Advanced life support services (ALS) delivered by paramedics that operate separately from the agency that provides the ambulance transport are not covered.
Annual routine physical exam We cover one visit per calendar year. The exam services include:	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the annual routine physical exam.

Services that are covered for you	What you must pay when you get these services
• Visual inspection of the body • Tapping specific areas of the body and listening to sounds • Checking vital signs and measuring height/weight	
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every calendar year. **Note**: Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the annual wellness visit.
Bathroom safety devices* This benefit is part of your Durable Medicare Equipment benefit. (For a definition of "durable medical equipment," see Chapter 12 of the *Evidence of Coverage*.) Covered services are limited to: • Shower chairs/seats - 1 every 3 years • Grab bars - 1 every 3 years	**In-Network:** 0% coinsurance **Out-of-Network:** 0% coinsurance
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.

Services that are covered for you	What you must pay when you get these services
quality, including a physician's interpretation of the results.	
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 (includes 3D mammogram) • One screening mammogram every calendar year for women aged 40 and older (includes 3D mammogram) • Clinical breast exams once every calendar year	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for covered screening mammograms. A screening mammogram may convert to a diagnostic mammogram at the time services are rendered. Diagnostic testing will be subject to diagnostic cost sharing.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	**In-Network:** $0 copay per service **Out-of-Network:** 0% coinsurance per service
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.

Services that are covered for you	What you must pay when you get these services
elevated risk of cardiovascular disease) once every 5 years (60 months).	
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every calendar year	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services* Covered services include: • We cover only manual manipulation of the spine to correct subluxation	**In-Network:** $0 copay per Medicare-covered visit **Out-of-Network:** $0 copay per Medicare-covered visit
Colorectal cancer screening For people 45 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months • Screening CT Colonography for people ages 45-75 years old once every five years One of the following every calendar year: • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) DNA based colorectal screening every 3 years For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover:	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. If the screening test results in a biopsy or removal of a lesion or growth, the procedure is considered diagnostic and outpatient surgery cost sharing may apply.

Services that are covered for you	What you must pay when you get these services
• Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy	
Depression screening We cover one screening for depression per calendar year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for an annual depression screening visit.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.
Diabetes self-management training, diabetic services and supplies* For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.	**In-Network:** There is no coinsurance, copayment, or deductible for diabetic self-management training 0% coinsurance for diabetic supplies and therapeutic shoes

Services that are covered for you	What you must pay when you get these services
• For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions. • For persons at risk of diabetes: Fasting plasma glucose tests are covered 2 times per calendar year. • You must obtain diabetic testing supplies from Durable Medical Equipment (DME) suppliers. Diabetic testing supplies may be covered if purchased at an approved retail pharmacy. Call Member Service for details. • Certain DME providers in the Freedom Blue PPO network have agreed to provide blood glucose monitors free of charge. Call Member Service for details.	**Out-of-Network:** 0% coinsurance for diabetic supplies and therapeutic shoes
Durable medical equipment (DME) and related supplies* (For a definition of "durable medical equipment," see Chapter 12 and Chapter 3, Section 7 of the *Evidence of Coverage*.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your	**In-Network:** **Durable Medical Equipment:** 0% coinsurance for Medicare-covered items Your cost sharing for Medicare oxygen equipment coverage is 0%, every month. After 36 months you no longer will pay the cost of the oxygen equipment but you will continue to pay 0% for the oxygen contents.

Services that are covered for you	What you must pay when you get these services
area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at medicare.highmark.com. Reimbursement for oxygen services includes payment for equipment rental, oxygen contents, and all accessories and supplies as necessary. Payment for deluxe or special features for durable medical equipment may be made only when such features are prescribed by the attending physician and when medical necessity is established. ***Prior authorization is required for certain items**	**Out-of-Network:** **Durable Medical Equipment:** 0% coinsurance for Medicare-covered items **Oxygen and Oxygen Related Equipment:** 0% coinsurance for oxygen and oxygen related equipment *DME items must be purchased from a Medicare participating provider.*
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. ***Emergency care is covered worldwide.***	**In and Out-of-Network (including worldwide):** $0 copay If you are admitted to the hospital within 3 days for the same condition, you pay $0 for the emergency room visit. The emergency room copayment applies if you are in the hospital for observation or rapid treatment as these are not considered hospital admissions.

Services that are covered for you	What you must pay when you get these services
Foreign Travel*	
Inpatient Facility care received outside of the US which is not covered by Medicare but which meets Medicare criteria for inpatient care within the US (maximum of 150 days/year) Services must be approved by Highmark.	Inpatient and outpatient facility services 0% coinsurance
Outpatient Facility services not covered by Medicare because they were received outside of the US (but which would otherwise be defined by Medicare as covered services). Services must be approved by Highmark.	Professional services 80% coinsurance of the Highmark Delaware Plan Allowance (Member also pays any amount exceeding the Highmark Delaware Plan Allowance)
Professional Provider services not covered by Medicare because they were received outside of the US (but which would otherwise be defined by Medicare as covered services)	
Health and wellness education programs Highmark's health and wellness education program provides access to network gyms and fitness classes designed to improve muscular strength and endurance, mobility, flexibility, range of motion, balance, agility and coordination through the Tivity, Inc. SilverSneakers® Fitness program. Eligible members receive a membership at network fitness facilities with access to all basic amenities plus SilverSneakers® fitness classes. SilverSneakers FLEX™ classes (which include tai chi, yoga and dance) are in neighborhood locations such as medical campuses, older-adult living communities and parks. SilverSneakers Steps®, which includes various kits for members to use at home or when they travel, is an available alternative for members who can't get to a network fitness location. For more information, to find SilverSneakers fitness locations and FLEX™ classes, or to get started with SilverSneakers Steps®, eligible	**In-Network:** There is no charge for the fitness program. **Out-of-Network (Fitness Facilities Outside of the SilverSneakers Network):** ✓ Because of the unique nature of health and wellness programs, the availability of comparable, equivalent programs may be limited. Program memberships or monthly dues that qualify for benefit coverage are subject to a 50% coinsurance after satisfying a $500 deductible which is not applied to the medical out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
members should visit silversneakers.com or call **1-888-423-4632** (TTY: 711 National Relay Service), Monday through Friday, 8:00 a.m. to 8:00 p.m., Eastern Time.	
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. *Routine hearing services are not covered.*	**In-Network:** $0 copay per Medicare-covered hearing exam **Out-of-Network:** $0 copay per Medicare-covered hearing exam
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every calendar year For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
Home health agency care* Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to:	**In-Network:** 0% coinsurance per visit **Out-of-Network:** 0% coinsurance per visit

Services that are covered for you	What you must pay when you get these services
• Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier ***Prior authorization is required for certain Part B drugs.**	**In-Network:** 0% coinsurance per visit **Out-of-Network:** 0% coinsurance per visit Medicare Part B drugs that are billed separately may be billed under the *Medicare Part B prescription drug* benefit (see below).

Services that are covered for you	What you must pay when you get these services
Hospice care You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you are admitted to a hospice you have the right to remain in your plan; if you chose to remain in your plan you must continue to pay plan premiums. <u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis:</u> Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost sharing. <u>For services that are covered by Medicare Part A or B and are not related to your terminal prognosis:</u> If you need non-emergency, non-urgently needed services that are covered	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not PPO. **In-Network:** $0 copay for a one time only hospice consultation with a primary care physician **Out-of-Network:** $0 copay for a one time only hospice consultation with a primary care physician

Services that are covered for you	What you must pay when you get these services
under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (such as if there is a requirement to obtain prior authorization). • If you obtain the covered services from a network provider and follow plan rules for obtaining service, you only pay the plan cost sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay the plan cost sharing for out-of-network services For services that are covered by Freedom Blue PPO PPO but are not covered by Medicare Part A or B: Freedom Blue PPO will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost sharing amount for these services. **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B and COVID-19 vaccines.

Services that are covered for you	What you must pay when you get these services
• Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccine • Other vaccines if you are at risk and they meet Medicare Part B coverage rules	
Inpatient hospital care* Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. Covered services include but are not limited to: • COVID-19 related services and stay requirements • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Private Duty Nursing • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services	If a patient is admitted for an Inpatient Acute Hospital Care stay due to COVID-19, the cost share for this service will be waived both in and out-of-network. Inpatient rehabilitation is not included. **In-Network:** 0% coinsurance per admission **Out-of-Network:** 0% coinsurance per admission Private Duty Nursing in an acute hospital setting is covered. You pay 20% coinsurance up to a 240 hour maximum within a 12 month period. You pay 100% after the maximum hours are met. The cost sharing for Privaty Duty Nursing is not applied to your Out of Pocket Maximum.

Services that are covered for you	What you must pay when you get these services
• Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If PPO provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion up to a $10,000 allowance (some restrictions apply). Items not directly related to travel and lodging expenses are not payable. Please contact Member Service for more information. • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.	

Services that are covered for you	What you must pay when you get these services
You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	
Inpatient services in a psychiatric hospital* • Covered services include mental health care services that require a hospital stay. • There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. • The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital.	**In-Network:** 0% coinsurance per admission **Out-of-Network:** 0% coinsurance per admission
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay* If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts, and other devices used to reduce fractures and dislocations	**In-Network:** $0 copay per primary care visit $0 copay per specialist visit $0 copay per radiation therapy visit 0% coinsurance for each advanced imaging service 0% coinsurance for lab services, x-rays and diagnostic procedures and tests 0% coinsurance for DME, prosthetics and orthotics 0% coinsurance for oxygen and oxygen related equipment $0 copay per therapy type, per provider, per visit for rehabilitation services

Services that are covered for you	What you must pay when you get these services
• Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy	**Out-of-Network:** $0 copay per primary care visit $0 copay per specialist visit 0% coinsurance per radiation therapy visit 0% coinsurance for diagnostic procedures, tests and lab services, advanced imaging services, outpatient x-ray, and diagnostic radiology services $0 copay per therapy type, per provider, per visit for rehabilitation services 0% coinsurance for DME, prosthetics and orthotics 0% coinsurance for oxygen and oxygen related equipment
 **Meal benefit** Upon discharge from an inpatient hospital stay, you are eligible for up to 2 meals per day for 14 days to be delivered to your home. Benefit does not include discharge to or from a Skilled Nursing Facility. The benefit must be activated within 30 days of discharge and is limited to once per calendar year. Eligible members will be contacted to confirm enrollment to start the meals benefit.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for this benefit.
 **Medical nutrition therapy** This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.

Services that are covered for you	What you must pay when you get these services
We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage Plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	
 **Medicare Diabetes Prevention Program (MDPP)** MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the MDPP benefit.
Medicare Part B prescription drugs* These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan	**In-Network:** Certain categories of Medicare Part B drugs are covered in full. These categories include certain vaccines, toxoids, pathology drugs, laboratory drugs, contrast materials, and miscellaneous drugs and solutions. 0% coinsurance for Medicare Part B Chemotherapy Drugs, associated administration services and all other Medicare Part B drugs

Services that are covered for you	What you must pay when you get these services
• Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, or Aranesp®) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: HighmarkStepBTargets.com We also cover some vaccines under our Part B prescription drug benefit.	**Out-of-Network:** 0% coinsurance for Medicare Part B Chemotherapy Drugs, associated administration services and all other Medicare Part B drugs
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.

Services that are covered for you	What you must pay when you get these services
Please note: *Commercial weight loss programs (such as, but not limited to, Weight Watchers, Jenny Craig and Nutri-System) are not eligible.*	
Opioid treatment program services* Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications. • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	**In-Network:** $0 copay per individual or group visit **Out-of-Network:** $0 copay per individual or group visit
Outpatient diagnostic tests and therapeutic services and supplies* Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Advanced imaging services (such as CT scans and MRIs)	**In-Network:** 0% coinsurance for lab services, diagnostic procedures and tests, x-rays, and diagnostic radiology services including those performed in a freestanding lab, physicians office, or outpatient hospital facility 0% coinsurance for advanced imaging services/ diagnostic radiology tests $0 copay for therapeutic radiology services There is no coinsurance, copayment, or deductible for outpatient blood. **Out-of-Network:** 0% coinsurance for diagnostic procedures, tests and lab services, advanced imaging services,

Services that are covered for you	What you must pay when you get these services
• Blood – including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need • Other outpatient diagnostic tests	outpatient x-ray, outpatient blood, and diagnostic radiology services
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note**: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	**In-Network:** 0% coinsurance **Out-of-Network:** 0% coinsurance Self-administered drugs covered under Part D that are administered in an outpatient setting cannot be billed under the medical coverage and must be submitted through your Medicare Part D coverage.
Outpatient hospital services*	**In-Network:** $0 copay for emergency services

Services that are covered for you	What you must pay when you get these services
We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Advanced imaging services (such as CT scan and MRI) • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call	0% coinsurance per visit, per provider, per day for surgery performed in an ambulatory surgical center or outpatient hospital setting 0% coinsurance for partial hospitalization services $0 copay for each individual or group therapy visit for other mental health care services 0% coinsurance or lab services, diagnostic procedures and tests, x-rays and diagnostic radiology services 0% coinsurance for advanced imaging services (MRI, MRA, CT and PET scan) 0% coinsurance for durable medical equipment (DME) items 0% coinsurance for Medicare Part B Chemotherapy Drugs, associated administration services and all other Medicare Part B drugs **Out-of-Network:** $0 copay for emergency services 0% coinsurance for services at an ambulatory surgical center and/or outpatient hospital facility visit 0% coinsurance for diagnostic procedures, tests and lab services, x-ray and outpatient blood 0% coinsurance for advanced imaging services (MRI, MRA, CT and PET scan) $0 copay for each individual or group therapy visit for mental health services 0% coinsurance for Medicare-covered durable medical equipment (DME) items 0% coinsurance for Medicare Part B Chemotherapy Drugs, associated administration services and all other Medicare Part B drugs

Services that are covered for you	What you must pay when you get these services
1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	
Outpatient mental health care* Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.	**In-Network:** $0 copay for each individual or group therapy visit **Out-of-Network:** $0 copay for each individual or group therapy visit
Outpatient rehabilitation services* Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	**In-Network:** $0 copay per therapy, per provider, per visit **Out-of-Network:** $0 copay per therapy type, per provider, per visit
Outpatient substance abuse services* Individual and group therapy visits on an outpatient basis for substance abuse.	**Network:** $0 copay per individual or group visit **Out-of-Network:** $0 copay per individual or group visit
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers* **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost sharing amounts for outpatient surgery. Even if you	**In-Network:** 0% coinsurance per service, per day, per provider **Out-of-Network:** 0% coinsurance per service, per day, per provider

Services that are covered for you	What you must pay when you get these services
stay in the hospital overnight, you might still be considered an "outpatient."	
Partial hospitalization services* "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service, or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	**In-Network:** 0% coinsurance **Out-of-Network:** 0% coinsurance
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment • Certain telehealth services, including: acute care home health, mental health, psychiatric, opioid treatment, substance abuse, occupational, physical and speech therapies ◦ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth.	Services that are available via telehealth are listed in the description of this benefit. The cost sharing for an in-person or telehealth visit will be the same for the type of service. **In-Network:** $0 copay per primary care in-person or telehealth visit $0 copay per specialist in-person or telehealth visit $0 copay per non-routine (Medicare-covered) dental in-person visit $0 copay per non-routine (Medicare-covered) hearing in-person visit 0% coinsurance per service, per day, per provider for each ambulatory surgical center and/or outpatient hospital facility visit **Out-of-Network:** $0 copay per primary care in-person or telehealth visit $0 copay per specialist in-person or telehealth visit $0 copay per non-routine (Medicare-covered) dental in-person visit

Services that are covered for you	What you must pay when you get these services
◦ Telehealth services are available using interactive audio and video telecommunications on your computer, tablet or mobile device. • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: ◦ You have an in-person visit within 6 months prior to your first telehealth visit ◦ You have an in-person visit every 12 months while receiving these telehealth services ◦ Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers	0% coinsurance for services at an ambulatory surgical center and/or outpatient hospital facility visit

Services that are covered for you	What you must pay when you get these services
• Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**: ◦ You're not a new patient **and** ◦ The check-in isn't related to an office visit in the past 7 days **and** ◦ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**: ◦ You're not a new patient **and** ◦ The evaluation isn't related to an office visit in the past 7 days **and** ◦ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record • Second opinion prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)	
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs)	**In-Network:** $0 copay per Medicare-covered visit **Out-of-Network:**

Services that are covered for you	What you must pay when you get these services
• Routine foot care for members with certain medical conditions affecting the lower limbs	$0 copay per Medicare-covered visit
Prostate cancer screening exams For men age 50 and older, covered services include the following once every calendar year: • Digital rectal exam • Prostate Specific Antigen (PSA) test	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for an annual PSA test.
Prosthetic devices and related supplies* Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" later in this section for more detail.	**In-Network:** 0% coinsurance for Medicare-covered items **Out-of-Network:** 0% coinsurance for Medicare-covered items
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	**In-Network:** $0 copay per visit **Out-of-Network:** 0% coinsurance per visit
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening per calendar year for adults with Medicare (including pregnant women) who misuse alcohol but aren't alcohol dependent.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.

Services that are covered for you	What you must pay when you get these services
If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	
 **Screening for lung cancer with low dose computed tomography (LDCT)** For qualified individuals, a LDCT is covered every calendar year. **Eligible members are:** people aged 50 – 80 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT.

Services that are covered for you	What you must pay when you get these services
 **Screening for sexually transmitted infections (STIs) and counseling to prevent STIs** We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
Services to treat kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3 of the *Evidence of Coverage*, or when your provider for this service is temporarily unavailable or inaccessible)	Renal dialysis when temporarily out of the service area is covered according to Medicare guidelines at the network cost share. Maximum coinsurance applies when enrollees choose to go to a non-network provider while in the Medicare Advantage National PPO service area. **In-Network:** $0 copay for kidney disease education services $0 copay for renal dialysis **Out-of-Network:** 0% coinsurance for renal dialysis

Services that are covered for you	What you must pay when you get these services
• Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, "Medicare Part B prescription drugs."	
Skilled nursing facility (SNF) care* (For a definition of "skilled nursing facility care," see Chapter 12 of the *Evidence of Coverage*. Skilled nursing facilities are sometimes called "SNFs.") 100 days covered for each benefit period Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (this includes substances that are naturally present in the body, such as blood clotting factors.)	A benefit period starts the day you are admitted at a Medicare-certified hospital or skilled nursing facility. It ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. **In-Network:** 0% coinsurance per admission for days 1-100 **Out-of-Network:** 0% coinsurance per admission for days 1-100

Services that are covered for you	What you must pay when you get these services
• Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse is living at the time you leave the hospital	
 **Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)** If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.

Services that are covered for you	What you must pay when you get these services
medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits.	
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	**In-Network:** $0 copay per visit **Out-of-Network:** 0% coinsurance per visit

Services that are covered for you	What you must pay when you get these services
Telehealth - Remote Access Provides access to in-network visits using interactive audio and video telecommunications on your computer, tablet or mobile device if offered by your PCP or Specialist. Coverage is limited to the following conditions: • medication reconciliation post-discharge • nutritional counseling • pharmacy clinic counseling (chronic disease and medication management) Any other conditions or services would not be covered. *Telehealth out-of-network services are not subject to the maximum out-of-pocket.*	**In-Network:** $0 copay per PCP visit $0 copay per specialist visit **Out-of-Network:** $0 copay per primary care visit $0 copay per specialist visit
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. Examples of urgently needed services that the plan must cover out of network are i) you need immediate care during the weekend, or ii) you are temporarily outside the service area of the plan. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. **Urgently needed services are covered worldwide.**	**In and Out-of-Network (including worldwide):** $0 copay per visit

Services that are covered for you	What you must pay when you get these services
 **Vision care** Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) A $200 benefit maximum applies to upgrades to post cataract surgery eyewear that are not medically necessary. Benefit maximum is available following cataract surgery once per operated eye.	**In-Network:** $0 copay per Medicare-covered eye exam **Out-of-Network:** $0 copay per Medicare-covered eye exam
 **"Welcome to Medicare" preventive visit** The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education	**In and Out-of-Network:** There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit.

Services that are covered for you	What you must pay when you get these services
and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.	

ADDITIONAL PLAN INFORMATION

Upon enrollment into Freedom Blue PPO, you agree to the following:

Freedom Blue PPO will notify you in writing of your confirmed effective date of enrollment into Freedom Blue PPO. Typically, your effective date will be the 1st day of the month that the State of Delaware enrollment lists as your effective date for the Freedom Blue PPO plan.

Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield Delaware is a PPO plan with a Medicare contract. Enrollment in Highmark BCBSD Inc. or Freedom Blue PPO depends on contract renewal.

You will need to keep your Medicare Parts A and Part B. You can be in only one Medicare Advantage plan at a time, and you understand that your enrollment in this plan will automatically end your enrollment in another Medicare health plan or prescription drug plan (other than the State of Delaware Part D Prescription Drug plan).

Once you are a member of Freedom Blue PPO, you have the right to appeal Plan decisions about payment or services if you disagree. This document along with the Freedom Blue PPO Evidence of Coverage (which is available to you) contains a full summary of the coverage rules associated with this plan. Other marketing materials present only highlights of the plan and not full coverage details.

If medically necessary, Freedom Blue PPO provides claims payment for all covered benefits, even if you get services out-of-network. Services authorized by Freedom Blue PPO and other services contained in the Freedom Blue PPO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without prior authorization (when required for select plan benefits), **neither Medicare nor Freedom Blue PPO will pay for the services**.

RELEASE OF INFORMATION:

Upon enrollment into this Medicare health plan, you acknowledge that Freedom Blue PPO will release your information to Medicare and other plans as is necessary for treatment, payment, and healthcare operations. You also acknowledge that Freedom Blue PPO will release your information to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.