Cancer Codes	Descriptions
C00.0	Malignant neoplasm of external upper lip
C00.1	Malignant neoplasm of external lower lip
C00.2	Malignant neoplasm of external lip, unspecified
C00.3	Malignant neoplasm of upper lip, inner aspect
C00.4	Malignant neoplasm of lower lip, inner aspect
C00.5	Malignant neoplasm of lip, unspecified, inner aspect
C00.6	Malignant neoplasm of commissure of lip, unspecified
C00.8	Malignant neoplasm of overlapping sites of lip
C00.9	Malignant neoplasm of lip, unspecified
C01	Malignant neoplasm of base of tongue
C02.0	Malignant neoplasm of dorsal surface of tongue
C02.1	Malignant neoplasm of border of tongue
C02.2	Malignant neoplasm of ventral surface of tongue
C02.3	Malignant neoplasm of anterior two-thirds of tongue, part unspecified
C02.4	Malignant neoplasm of lingual tonsil
C02.8	Malignant neoplasm of overlapping sites of tongue
C02.9	Malignant neoplasm of tongue, unspecified
C03.0	Malignant neoplasm of upper gum
C03.1	Malignant neoplasm of lower gum
C03.9	Malignant neoplasm of gum, unspecified
C04.0	Malignant neoplasm of anterior floor of mouth
C04.1	Malignant neoplasm of lateral floor of mouth
C04.8	Malignant neoplasm of overlapping sites of floor of mouth
C04.9	Malignant neoplasm of floor of mouth, unspecified
C05.0	Malignant neoplasm of hard palate
C05.1	Malignant neoplasm of soft palate
C05.2	Malignant neoplasm of uvula
C05.8	Malignant neoplasm of overlapping sites of palate
C05.9	Malignant neoplasm of palate, unspecified
C06.0	Malignant neoplasm of cheek mucosa
C06.1	Malignant neoplasm of vestibule of mouth
C06.2	Malignant neoplasm of retromolar area
C06.80	Malignant neoplasm of overlapping sites of unspecified parts of mouth
C06.89	Malignant neoplasm of overlapping sites of other parts of mouth
C06.9	Malignant neoplasm of mouth, unspecified
C07	Malignant neoplasm of parotid gland
C08.0	Malignant neoplasm of submandibular gland
C08.1	Malignant neoplasm of sublingual gland
C08.9	Malignant neoplasm of major salivary gland, unspecified
C09.0	Malignant neoplasm of tonsillar fossa
C09.1	Malignant neoplasm of tonsillar pillar (anterior) (posterior)
C09.8	Malignant neoplasm of overlapping sites of tonsil

C09.9	Malignant neoplasm of tonsil, unspecified
C10.0	Malignant neoplasm of vallecula
C10.1	Malignant neoplasm of anterior surface of epiglottis
C10.2	Malignant neoplasm of lateral wall of oropharynx
C10.3	Malignant neoplasm of posterior wall of oropharynx
C10.4	Malignant neoplasm of branchial cleft
C10.8	Malignant neoplasm of overlapping sites of oropharynx
C10.9	Malignant neoplasm of oropharynx, unspecified
C11.0	Malignant neoplasm of superior wall of nasopharynx
C11.1	Malignant neoplasm of posterior wall of nasopharynx
C11.2	Malignant neoplasm of lateral wall of nasopharynx
C11.3	Malignant neoplasm of anterior wall of nasopharynx
C11.8	Malignant neoplasm of overlapping sites of nasopharynx
C11.9	Malignant neoplasm of nasopharynx, unspecified
C12	Malignant neoplasm of pyriform sinus
C13.0	Malignant neoplasm of postcricoid region
C13.1	Malignant neoplasm of aryepiglottic fold, hypopharyngeal aspect
C13.2	Malignant neoplasm of posterior wall of hypopharynx
C13.8	Malignant neoplasm of overlapping sites of hypopharynx
C13.9	Malignant neoplasm of hypopharynx, unspecified
C14.0	Malignant neoplasm of pharynx, unspecified
C14.2	Malignant neoplasm of Waldeyer's ring
C14.8	Malignant neoplasm of overlapping sites of lip, oral cavity and pharynx
C15.3	Malignant neoplasm of upper third of esophagus
C15.4	Malignant neoplasm of middle third of esophagus
C15.5	Malignant neoplasm of lower third of esophagus
C15.8	Malignant neoplasm of overlapping sites of esophagus
C15.9	Malignant neoplasm of esophagus, unspecified
C16.0	Malignant neoplasm of cardia
C16.1	Malignant neoplasm of fundus of stomach
C16.2	Malignant neoplasm of body of stomach
C16.3	Malignant neoplasm of pyloric antrum
C16.4	Malignant neoplasm of pylorus
C16.5	Malignant neoplasm of lesser curvature of stomach, unspecified
C16.6	Malignant neoplasm of greater curvature of stomach, unspecified
C16.8	Malignant neoplasm of overlapping sites of stomach
C16.9	Malignant neoplasm of stomach, unspecified
C17.0	Malignant neoplasm of duodenum
C17.1	Malignant neoplasm of jejunum
C17.2	Malignant neoplasm of ileum
C17.3	Meckel's diverticulum, malignant
C17.8	Malignant neoplasm of overlapping sites of small intestine
C17.9	Malignant neoplasm of small intestine, unspecified
C18.0	Malignant neoplasm of cecum

C18.1	Malignant neoplasm of appendix
C18.2	Malignant neoplasm of ascending colon
C18.3	Malignant neoplasm of hepatic flexure
C18.4	Malignant neoplasm of transverse colon
C18.5	Malignant neoplasm of splenic flexure
C18.6	Malignant neoplasm of descending colon
C18.7	Malignant neoplasm of sigmoid colon
C18.8	Malignant neoplasm of overlapping sites of colon
C18.9	Malignant neoplasm of colon, unspecified
C19	Malignant neoplasm of rectosigmoid junction
C20	Malignant neoplasm of rectum
C21.0	Malignant neoplasm of anus, unspecified
C21.1	Malignant neoplasm of anal canal
C21.2	Malignant neoplasm of cloacogenic zone
C21.8	Malignant neoplasm of overlapping sites of rectum, anus and anal canal
C22.0	Liver cell carcinoma
C22.1	Intrahepatic bile duct carcinoma
C22.2	Hepatoblastoma
C22.3	Angiosarcoma of liver
C22.4	Other sarcomas of liver
C22.7	Other specified carcinomas of liver
C22.8	Malignant neoplasm of liver, primary, unspecified as to type
C22.9	Malignant neoplasm of liver, not specified as primary or secondary
C23	Malignant neoplasm of gallbladder
C24.0	Malignant neoplasm of extrahepatic bile duct
C24.1	Malignant neoplasm of ampulla of Vater
C24.8	Malignant neoplasm of overlapping sites of biliary tract
C24.9	Malignant neoplasm of biliary tract, unspecified
C25.0	Malignant neoplasm of head of pancreas
C25.1	Malignant neoplasm of body of pancreas
C25.2	Malignant neoplasm of tail of pancreas
C25.3	Malignant neoplasm of pancreatic duct
C25.4	Malignant neoplasm of endocrine pancreas
C25.7	Malignant neoplasm of other parts of pancreas
C25.8	Malignant neoplasm of overlapping sites of pancreas
C25.9	Malignant neoplasm of pancreas, unspecified
C26.0	Malignant neoplasm of intestinal tract, part unspecified
C26.1	Malignant neoplasm of spleen
C26.9	Malignant neoplasm of ill-defined sites within the digestive system
C30.0	Malignant neoplasm of nasal cavity
C30.1	Malignant neoplasm of middle ear
C31.0	Malignant neoplasm of maxillary sinus
C31.1	Malignant neoplasm of ethmoidal sinus
C31.2	Malignant neoplasm of frontal sinus

C31.3	Malignant neoplasm of sphenoid sinus
C31.8	Malignant neoplasm of overlapping sites of accessory sinuses
C31.9	Malignant neoplasm of accessory sinus, unspecified
C32.0	Malignant neoplasm of glottis
C32.1	Malignant neoplasm of supraglottis
C32.2	Malignant neoplasm of subglottis
C32.3	Malignant neoplasm of laryngeal cartilage
C32.8	Malignant neoplasm of overlapping sites of larynx
C32.9	Malignant neoplasm of larynx, unspecified
C33	Malignant neoplasm of trachea
C34.00	Malignant neoplasm of unspecified main bronchus
C34.01	Malignant neoplasm of right main bronchus
C34.10	Malignant neoplasm of upper lobe, unspecified bronchus or lung
C34.11	Malignant neoplasm of upper lobe, right bronchus or lung
C34.12	Malignant neoplasm of upper lobe, left bronchus or lung
C34.02	Malignant neoplasm of left main bronchus
C34.2	Malignant neoplasm of middle lobe, bronchus or lung
C34.30	Malignant neoplasm of lower lobe, unspecified bronchus or lung
C34.31	Malignant neoplasm of lower lobe, right bronchus or lung
C34.32	Malignant neoplasm of lower lobe, left bronchus or lung
C34.80	Malignant neoplasm of overlapping sites of unspecified bronchus and lung
C34.81	Malignant neoplasm of overlapping sites of right bronchus and lung
C34.82	Malignant neoplasm of overlapping sites of left bronchus and lung
C34.90	Malignant neoplasm of unspecified part of unspecified bronchus or lung
C34.91	Malignant neoplasm of unspecified part of right bronchus or lung
C34.92	Malignant neoplasm of unspecified part of left bronchus or lung
C37	Malignant neoplasm of thymus
C38.0	Malignant neoplasm of heart
C38.1	Malignant neoplasm of anterior mediastinum
C38.2	Malignant neoplasm of posterior mediastinum
C38.3	Malignant neoplasm of mediastinum, part unspecified
C38.4	Malignant neoplasm of pleura
C38.8	Malignant neoplasm of overlapping sites of heart, mediastinum and pleura
C39.0	Malignant neoplasm of upper respiratory tract, part unspecified
C39.9	Malignant neoplasm of lower respiratory tract, part unspecified
C40.00	Malignant neoplasm of scapula and long bones of unspecified upper limb
C40.01	Malignant neoplasm of scapula and long bones of right upper limb
C40.10	Malignant neoplasm of short bones of unspecified upper limb
C40.11	Malignant neoplasm of short bones of right upper limb
C40.12	Malignant neoplasm of short bones of left upper limb
C40.02	Malignant neoplasm of scapula and long bones of left upper limb
C40.20	Malignant neoplasm of long bones of unspecified lower limb
C40.21	Malignant neoplasm of long bones of right lower limb
C40.22	Malignant neoplasm of long bones of left lower limb

C40.30	Malignant neoplasm of short bones of unspecified lower limb
C40.31	Malignant neoplasm of short bones of right lower limb
C40.32	Malignant neoplasm of short bones of left lower limb
C40.80	Malignant neoplasm of overlapping sites of bone and articular cartilage of unspecified limb
C40.81	Malignant neoplasm of overlapping sites of bone and articular cartilage of right limb
C40.82	Malignant neoplasm of overlapping sites of bone and articular cartilage of left limb
C40.90	Malignant neoplasm of unspecified bones and articular cartilage of unspecified limb
C40.91	Malignant neoplasm of unspecified bones and articular cartilage of right limb
C40.92	Malignant neoplasm of unspecified bones and articular cartilage of left limb
C41.0	Malignant neoplasm of bones of skull and face
C41.1	Malignant neoplasm of mandible
C41.2	Malignant neoplasm of vertebral column
C41.3	Malignant neoplasm of ribs, sternum and clavicle
C41.4	Malignant neoplasm of pelvic bones, sacrum and coccyx
C41.9	Malignant neoplasm of bone and articular cartilage, unspecified
C43.0	Malignant melanoma of lip
C43.10	Malignant melanoma of unspecified eyelid, including canthus
C43.111	Malignant melanoma of right upper eyelid, including canthus
C43.112	Malignant melanoma of right lower eyelid, including canthus
C43.121	Malignant melanoma of left upper eyelid, including canthus
C43.122	Malignant melanoma of left lower eyelid, including canthus
C43.20	Malignant melanoma of unspecified ear and external auricular canal
C43.21	Malignant melanoma of right ear and external auricular canal
C43.22	Malignant melanoma of left ear and external auricular canal
C43.30	Malignant melanoma of unspecified part of face
C43.31	Malignant melanoma of nose
C43.39	Malignant melanoma of other parts of face
C43.4	Malignant melanoma of scalp and neck
C43.51	Malignant melanoma of anal skin
C43.52	Malignant melanoma of skin of breast
C43.59	Malignant melanoma of other part of trunk
C43.60	Malignant melanoma of unspecified upper limb, including shoulder
C43.61	Malignant melanoma of right upper limb, including shoulder
C43.62	Malignant melanoma of left upper limb, including shoulder
C43.70	Malignant melanoma of unspecified lower limb, including hip
C43.71	Malignant melanoma of right lower limb, including hip
C43.72	Malignant melanoma of left lower limb, including hip
C43.8	Malignant melanoma of overlapping sites of skin
C43.9	Malignant melanoma of skin, unspecified
C44.00	Unspecified malignant neoplasm of skin of lip
C44.01	Basal cell carcinoma of skin of lip
C44.101	Unspecified malignant neoplasm of skin of unspecified eyelid, including canthus
C44.1021	Unspecified malignant neoplasm of skin of right upper eyelid, including canthus
C44.1022	Unspecified malignant neoplasm of skin of right lower eyelid, including canthus

C44.1091	Unspecified malignant neoplasm of skin of left upper eyelid, including canthus
C44.1092	Unspecified malignant neoplasm of skin of left lower eyelid, including canthus
C44.111	Basal cell carcinoma of skin of unspecified eyelid, including canthus
C44.1121	Basal cell carcinoma of skin of right upper eyelid, including canthus
C44.1122	Basal cell carcinoma of skin of right lower eyelid, including canthus
C44.1191	Basal cell carcinoma of skin of left upper eyelid, including canthus
C44.1192	Basal cell carcinoma of skin of left lower eyelid, including canthus
C44.121	Squamous cell carcinoma of skin of unspecified eyelid, including canthus
C44.1221	Squamous cell carcinoma of skin of right upper eyelid, including canthus
C44.1222	Squamous cell carcinoma of skin of right lower eyelid, including canthus
C44.1291	Squamous cell carcinoma of skin of left upper eyelid, including canthus
C44.1292	Squamous cell carcinoma of skin of left lower eyelid, including canthus
C44.131	Sebaceous cell carcinoma of skin of unspecified eyelid, including canthus
C44.1321	Sebaceous cell carcinoma of skin of right upper eyelid, including canthus
C44.1322	Sebaceous cell carcinoma of skin of right lower eyelid, including canthus
C44.1391	Sebaceous cell carcinoma of skin of left upper eyelid, including canthus
C44.1392	Sebaceous cell carcinoma of skin of left lower eyelid, including canthus
C44.191	Other specified malignant neoplasm of skin of unspecified eyelid, including canthus
C44.1921	Other specified malignant neoplasm of skin of right upper eyelid, including canthus
C44.1922	Other specified malignant neoplasm of skin of right lower eyelid, including canthus
C44.1991	Other specified malignant neoplasm of skin of left upper eyelid, including canthus
C44.1992	Other specified malignant neoplasm of skin of left lower eyelid, including canthus
C44.02	Squamous cell carcinoma of skin of lip
C44.201	Unspecified malignant neoplasm of skin of unspecified ear and external auricular canal
C44.202	Unspecified malignant neoplasm of skin of right ear and external auricular canal
C44.209	Unspecified malignant neoplasm of skin of left ear and external auricular canal
C44.211	Basal cell carcinoma of skin of unspecified ear and external auricular canal
C44.212	Basal cell carcinoma of skin of right ear and external auricular canal
C44.219	Basal cell carcinoma of skin of left ear and external auricular canal
C44.221	Squamous cell carcinoma of skin of unspecified ear and external auricular canal
C44.222	Squamous cell carcinoma of skin of right ear and external auricular canal
C44.229	Squamous cell carcinoma of skin of left ear and external auricular canal
C44.291	Other specified malignant neoplasm of skin of unspecified ear and external auricular canal
C44.292	Other specified malignant neoplasm of skin of right ear and external auricular canal
C44.299	Other specified malignant neoplasm of skin of left ear and external auricular canal
C44.300	Unspecified malignant neoplasm of skin of unspecified part of face
C44.301	Unspecified malignant neoplasm of skin of nose
C44.309	Unspecified malignant neoplasm of skin of other parts of face
C44.310	Basal cell carcinoma of skin of unspecified parts of face
C44.311	Basal cell carcinoma of skin of nose
C44.319	Basal cell carcinoma of skin of other parts of face
C44.320	Squamous cell carcinoma of skin of unspecified parts of face
C44.321	Squamous cell carcinoma of skin of nose
C44.329	Squamous cell carcinoma of skin of other parts of face

C44.390	Other specified malignant neoplasm of skin of unspecified parts of face
C44.391	Other specified malignant neoplasm of skin of nose
C44.399	Other specified malignant neoplasm of skin of other parts of face
C44.40	Unspecified malignant neoplasm of skin of scalp and neck
C44.41	Basal cell carcinoma of skin of scalp and neck
C44.42	Squamous cell carcinoma of skin of scalp and neck
C44.49	Other specified malignant neoplasm of skin of scalp and neck
C44.500	Unspecified malignant neoplasm of anal skin
C44.501	Unspecified malignant neoplasm of skin of breast
C44.509	Unspecified malignant neoplasm of skin of other part of trunk
C44.510	Basal cell carcinoma of anal skin
C44.511	Basal cell carcinoma of skin of breast
C44.519	Basal cell carcinoma of skin of other part of trunk
C44.520	Squamous cell carcinoma of anal skin
C44.521	Squamous cell carcinoma of skin of breast
C44.529	Squamous cell carcinoma of skin of other part of trunk
C44.590	Other specified malignant neoplasm of anal skin
C44.591	Other specified malignant neoplasm of skin of breast
C44.599	Other specified malignant neoplasm of skin of other part of trunk
C44.601	Unspecified malignant neoplasm of skin of unspecified upper limb, including shoulder
C44.602	Unspecified malignant neoplasm of skin of right upper limb, including shoulder
C44.609	Unspecified malignant neoplasm of skin of left upper limb, including shoulder
C44.611	Basal cell carcinoma of skin of unspecified upper limb, including shoulder
C44.612	Basal cell carcinoma of skin of right upper limb, including shoulder
C44.619	Basal cell carcinoma of skin of left upper limb, including shoulder
C44.621	Squamous cell carcinoma of skin of unspecified upper limb, including shoulder
C44.622	Squamous cell carcinoma of skin of right upper limb, including shoulder
C44.629	Squamous cell carcinoma of skin of left upper limb, including shoulder
C44.691	Other specified malignant neoplasm of skin of unspecified upper limb, including shoulder
C44.692	Other specified malignant neoplasm of skin of right upper limb, including shoulder
C44.699	Other specified malignant neoplasm of skin of left upper limb, including shoulder
C44.701	Unspecified malignant neoplasm of skin of unspecified lower limb, including hip
C44.702	Unspecified malignant neoplasm of skin of right lower limb, including hip
C44.709	Unspecified malignant neoplasm of skin of left lower limb, including hip
C44.711	Basal cell carcinoma of skin of unspecified lower limb, including hip
C44.712	Basal cell carcinoma of skin of right lower limb, including hip
C44.719	Basal cell carcinoma of skin of left lower limb, including hip
C44.721	Squamous cell carcinoma of skin of unspecified lower limb, including hip
C44.722	Squamous cell carcinoma of skin of right lower limb, including hip
C44.729	Squamous cell carcinoma of skin of left lower limb, including hip
C44.791	Other specified malignant neoplasm of skin of unspecified lower limb, including hip
C44.792	Other specified malignant neoplasm of skin of right lower limb, including hip
C44.799	Other specified malignant neoplasm of skin of left lower limb, including hip
C44.80	Unspecified malignant neoplasm of overlapping sites of skin

C44.81	Basal cell carcinoma of overlapping sites of skin
C44.82	Squamous cell carcinoma of overlapping sites of skin
C44.89	Other specified malignant neoplasm of overlapping sites of skin
C44.09	Other specified malignant neoplasm of skin of lip
C44.90	Unspecified malignant neoplasm of skin, unspecified
C44.91	Basal cell carcinoma of skin, unspecified
C44.92	Squamous cell carcinoma of skin, unspecified
C44.99	Other specified malignant neoplasm of skin, unspecified
C45.0	Mesothelioma of pleura
C45.1	Mesothelioma of peritoneum
C45.2	Mesothelioma of pericardium
C45.7	Mesothelioma of other sites
C45.9	Mesothelioma, unspecified
C46.0	Kaposi's sarcoma of skin
C46.1	Kaposi's sarcoma of soft tissue
C46.2	Kaposi's sarcoma of palate
C46.3	Kaposi's sarcoma of lymph nodes
C46.4	Kaposi's sarcoma of gastrointestinal sites
C46.50	Kaposi's sarcoma of unspecified lung
C46.51	Kaposi's sarcoma of right lung
C46.52	Kaposi's sarcoma of left lung
C46.7	Kaposi's sarcoma of other sites
C46.9	Kaposi's sarcoma, unspecified
C47.0	Malignant neoplasm of peripheral nerves of head, face and neck
C47.10	Malignant neoplasm of peripheral nerves of unspecified upper limb, including shoulder
C47.11	Malignant neoplasm of peripheral nerves of right upper limb, including shoulder
C47.12	Malignant neoplasm of peripheral nerves of left upper limb, including shoulder
C47.20	Malignant neoplasm of peripheral nerves of unspecified lower limb, including hip
C47.21	Malignant neoplasm of peripheral nerves of right lower limb, including hip
C47.22	Malignant neoplasm of peripheral nerves of left lower limb, including hip
C47.3	Malignant neoplasm of peripheral nerves of thorax
C47.4	Malignant neoplasm of peripheral nerves of abdomen
C47.5	Malignant neoplasm of peripheral nerves of pelvis
C47.6	Malignant neoplasm of peripheral nerves of trunk, unspecified
C47.8	Malignant neoplasm of overlapping sites of peripheral nerves and autonomic nervous system
C47.9	Malignant neoplasm of peripheral nerves and autonomic nervous system, unspecified
C48.0	Malignant neoplasm of retroperitoneum
C48.1	Malignant neoplasm of specified parts of peritoneum
C48.2	Malignant neoplasm of peritoneum, unspecified
C48.8	Malignant neoplasm of overlapping sites of retroperitoneum and peritoneum
C49.0	Malignant neoplasm of connective and soft tissue of head, face and neck
C49.10	Malignant neoplasm of connective and soft tissue of unspecified upper limb, including shoulder
C49.11	Malignant neoplasm of connective and soft tissue of right upper limb, including shoulder
C49.12	Malignant neoplasm of connective and soft tissue of left upper limb, including shoulder

C49.20	Malignant neoplasm of connective and soft tissue of unspecified lower limb, including hip
C49.21	Malignant neoplasm of connective and soft tissue of right lower limb, including hip
C49.22	Malignant neoplasm of connective and soft tissue of left lower limb, including hip
C49.3	Malignant neoplasm of connective and soft tissue of thorax
C49.4	Malignant neoplasm of connective and soft tissue of abdomen
C49.5	Malignant neoplasm of connective and soft tissue of pelvis
C49.6	Malignant neoplasm of connective and soft tissue of trunk, unspecified
C49.8	Malignant neoplasm of overlapping sites of connective and soft tissue
C49.9	Malignant neoplasm of connective and soft tissue, unspecified
C49.A0	Gastrointestinal stromal tumor, unspecified site
C49.A1	Gastrointestinal stromal tumor of esophagus
C49.A2	Gastrointestinal stromal tumor of stomach
C49.A3	Gastrointestinal stromal tumor of small intestine
C49.A4	Gastrointestinal stromal tumor of large intestine
C49.A5	Gastrointestinal stromal tumor of rectum
C49.A9	Gastrointestinal stromal tumor of other sites
C4A.0	Merkel cell carcinoma of lip
C4A.10	Merkel cell carcinoma of unspecified eyelid, including canthus
C4A.111	Merkel cell carcinoma of right upper eyelid, including canthus
C4A.112	Merkel cell carcinoma of right lower eyelid, including canthus
C4A.121	Merkel cell carcinoma of left upper eyelid, including canthus
C4A.122	Merkel cell carcinoma of left lower eyelid, including canthus
C4A.20	Merkel cell carcinoma of unspecified ear and external auricular canal
C4A.21	Merkel cell carcinoma of right ear and external auricular canal
C4A.22	Merkel cell carcinoma of left ear and external auricular canal
C4A.30	Merkel cell carcinoma of unspecified part of face
C4A.31	Merkel cell carcinoma of nose
C4A.39	Merkel cell carcinoma of other parts of face
C4A.4	Merkel cell carcinoma of scalp and neck
C4A.51	Merkel cell carcinoma of anal skin
C4A.52	Merkel cell carcinoma of skin of breast
C4A.59	Merkel cell carcinoma of other part of trunk
C4A.60	Merkel cell carcinoma of unspecified upper limb, including shoulder
C4A.61	Merkel cell carcinoma of right upper limb, including shoulder
C4A.62	Merkel cell carcinoma of left upper limb, including shoulder
C4A.70	Merkel cell carcinoma of unspecified lower limb, including hip
C4A.71	Merkel cell carcinoma of right lower limb, including hip
C4A.72	Merkel cell carcinoma of left lower limb, including hip
C4A.8	Merkel cell carcinoma of overlapping sites
C4A.9	Merkel cell carcinoma, unspecified
C50.011	Malignant neoplasm of nipple and areola, right female breast
C50.111	Malignant neoplasm of central portion of right female breast
C50.112	Malignant neoplasm of central portion of left female breast
C50.119	Malignant neoplasm of central portion of unspecified female breast

C50.012	Malignant neoplasm of nipple and areola, left female breast
C50.121	Malignant neoplasm of central portion of right male breast
C50.122	Malignant neoplasm of central portion of left male breast
C50.129	Malignant neoplasm of central portion of unspecified male breast
C50.019	Malignant neoplasm of nipple and areola, unspecified female breast
C50.021	Malignant neoplasm of nipple and areola, right male breast
C50.211	Malignant neoplasm of upper-inner quadrant of right female breast
C50.212	Malignant neoplasm of upper-inner quadrant of left female breast
C50.219	Malignant neoplasm of upper-inner quadrant of unspecified female breast
C50.022	Malignant neoplasm of nipple and areola, left male breast
C50.221	Malignant neoplasm of upper-inner quadrant of right male breast
C50.222	Malignant neoplasm of upper-inner quadrant of left male breast
C50.229	Malignant neoplasm of upper-inner quadrant of unspecified male breast
C50.029	Malignant neoplasm of nipple and areola, unspecified male breast
C50.311	Malignant neoplasm of lower-inner quadrant of right female breast
C50.312	Malignant neoplasm of lower-inner quadrant of left female breast
C50.319	Malignant neoplasm of lower-inner quadrant of unspecified female breast
C50.321	Malignant neoplasm of lower-inner quadrant of right male breast
C50.322	Malignant neoplasm of lower-inner quadrant of left male breast
C50.329	Malignant neoplasm of lower-inner quadrant of unspecified male breast
C50.411	Malignant neoplasm of upper-outer quadrant of right female breast
C50.412	Malignant neoplasm of upper-outer quadrant of left female breast
C50.419	Malignant neoplasm of upper-outer quadrant of unspecified female breast
C50.421	Malignant neoplasm of upper-outer quadrant of right male breast
C50.422	Malignant neoplasm of upper-outer quadrant of left male breast
C50.429	Malignant neoplasm of upper-outer quadrant of unspecified male breast
C50.511	Malignant neoplasm of lower-outer quadrant of right female breast
C50.512	Malignant neoplasm of lower-outer quadrant of left female breast
C50.519	Malignant neoplasm of lower-outer quadrant of unspecified female breast
C50.521	Malignant neoplasm of lower-outer quadrant of right male breast
C50.522	Malignant neoplasm of lower-outer quadrant of left male breast
C50.529	Malignant neoplasm of lower-outer quadrant of unspecified male breast
C50.611	Malignant neoplasm of axillary tail of right female breast
C50.612	Malignant neoplasm of axillary tail of left female breast
C50.619	Malignant neoplasm of axillary tail of unspecified female breast
C50.621	Malignant neoplasm of axillary tail of right male breast
C50.622	Malignant neoplasm of axillary tail of left male breast
C50.629	Malignant neoplasm of axillary tail of unspecified male breast
C50.811	Malignant neoplasm of overlapping sites of right female breast
C50.812	Malignant neoplasm of overlapping sites of left female breast
C50.819	Malignant neoplasm of overlapping sites of unspecified female breast
C50.821	Malignant neoplasm of overlapping sites of right male breast
C50.822	Malignant neoplasm of overlapping sites of left male breast
C50.829	Malignant neoplasm of overlapping sites of unspecified male breast

C50.911	Malignant neoplasm of unspecified site of right female breast
C50.912	Malignant neoplasm of unspecified site of left female breast
C50.919	Malignant neoplasm of unspecified site of unspecified female breast
C50.921	Malignant neoplasm of unspecified site of right male breast
C50.922	Malignant neoplasm of unspecified site of left male breast
C50.929	Malignant neoplasm of unspecified site of unspecified male breast
Z85.3	Personal history of malignant neoplasm of breast
C51.0	Malignant neoplasm of labium majus
C51.1	Malignant neoplasm of labium minus
C51.2	Malignant neoplasm of clitoris
C51.8	Malignant neoplasm of overlapping sites of vulva
C51.9	Malignant neoplasm of vulva, unspecified
C52	Malignant neoplasm of vagina
C53.0	Malignant neoplasm of endocervix
C53.1	Malignant neoplasm of exocervix
C53.8	Malignant neoplasm of overlapping sites of cervix uteri
C53.9	Malignant neoplasm of cervix uteri, unspecified
C54.0	Malignant neoplasm of isthmus uteri
C54.1	Malignant neoplasm of endometrium
C54.2	Malignant neoplasm of myometrium
C54.3	Malignant neoplasm of fundus uteri
C54.8	Malignant neoplasm of overlapping sites of corpus uteri
C54.9	Malignant neoplasm of corpus uteri, unspecified
C55	Malignant neoplasm of uterus, part unspecified
C56.1	Malignant neoplasm of right ovary
C56.2	Malignant neoplasm of left ovary
C56.3	Malignant neoplasm of bilateral ovaries
C56.9	Malignant neoplasm of unspecified ovary
C57.00	Malignant neoplasm of unspecified fallopian tube
C57.01	Malignant neoplasm of right fallopian tube
C57.10	Malignant neoplasm of unspecified broad ligament
C57.11	Malignant neoplasm of right broad ligament
C57.12	Malignant neoplasm of left broad ligament
C57.02	Malignant neoplasm of left fallopian tube
C57.20	Malignant neoplasm of unspecified round ligament
C57.21	Malignant neoplasm of right round ligament
C57.22	Malignant neoplasm of left round ligament
C57.3	Malignant neoplasm of parametrium
C57.4	Malignant neoplasm of uterine adnexa, unspecified
C57.7	Malignant neoplasm of other specified female genital organs
C57.8	Malignant neoplasm of overlapping sites of female genital organs
C57.9	Malignant neoplasm of female genital organ, unspecified
C58	Malignant neoplasm of placenta
C60.0	Malignant neoplasm of prepuce

C60.1	Malignant neoplasm of glans penis
C60.2	Malignant neoplasm of body of penis
C60.8	Malignant neoplasm of overlapping sites of penis
C60.9	Malignant neoplasm of penis, unspecified
C61	Malignant neoplasm of prostate
C62.00	Malignant neoplasm of unspecified undescended testis
C62.01	Malignant neoplasm of undescended right testis
C62.10	Malignant neoplasm of unspecified descended testis
C62.11	Malignant neoplasm of descended right testis
C62.12	Malignant neoplasm of descended left testis
C62.02	Malignant neoplasm of undescended left testis
C62.90	Malignant neoplasm of unspecified testis, unspecified whether descended or undescended
C62.91	Malignant neoplasm of right testis, unspecified whether descended or undescended
C62.92	Malignant neoplasm of left testis, unspecified whether descended or undescended
C63.00	Malignant neoplasm of unspecified epididymis
C63.01	Malignant neoplasm of right epididymis
C63.10	Malignant neoplasm of unspecified spermatic cord
C63.11	Malignant neoplasm of right spermatic cord
C63.12	Malignant neoplasm of left spermatic cord
C63.02	Malignant neoplasm of left epididymis
C63.2	Malignant neoplasm of scrotum
C63.7	Malignant neoplasm of other specified male genital organs
C63.8	Malignant neoplasm of overlapping sites of male genital organs
C63.9	Malignant neoplasm of male genital organ, unspecified
C64.1	Malignant neoplasm of right kidney, except renal pelvis
C64.2	Malignant neoplasm of left kidney, except renal pelvis
C64.9	Malignant neoplasm of unspecified kidney, except renal pelvis
C65.1	Malignant neoplasm of right renal pelvis
C65.2	Malignant neoplasm of left renal pelvis
C65.9	Malignant neoplasm of unspecified renal pelvis
C66.1	Malignant neoplasm of right ureter
C66.2	Malignant neoplasm of left ureter
C66.9	Malignant neoplasm of unspecified ureter
C67.0	Malignant neoplasm of trigone of bladder
C67.1	Malignant neoplasm of dome of bladder
C67.2	Malignant neoplasm of lateral wall of bladder
C67.3	Malignant neoplasm of anterior wall of bladder
C67.4	Malignant neoplasm of posterior wall of bladder
C67.5	Malignant neoplasm of bladder neck
C67.6	Malignant neoplasm of ureteric orifice
C67.7	Malignant neoplasm of urachus
C67.8	Malignant neoplasm of overlapping sites of bladder
C67.9	Malignant neoplasm of bladder, unspecified
C68.0	Malignant neoplasm of urethra

C68.1	Malignant neoplasm of paraurethral glands
C68.8	Malignant neoplasm of overlapping sites of urinary organs
C68.9	Malignant neoplasm of urinary organ, unspecified
C69.00	Malignant neoplasm of unspecified conjunctiva
C69.01	Malignant neoplasm of right conjunctiva
C69.10	Malignant neoplasm of unspecified cornea
C69.11	Malignant neoplasm of right cornea
C69.12	Malignant neoplasm of left cornea
C69.02	Malignant neoplasm of left conjunctiva
C69.20	Malignant neoplasm of unspecified retina
C69.21	Malignant neoplasm of right retina
C69.22	Malignant neoplasm of left retina
C69.30	Malignant neoplasm of unspecified choroid
C69.31	Malignant neoplasm of right choroid
C69.32	Malignant neoplasm of left choroid
C69.40	Malignant neoplasm of unspecified ciliary body
C69.41	Malignant neoplasm of right ciliary body
C69.42	Malignant neoplasm of left ciliary body
C69.50	Malignant neoplasm of unspecified lacrimal gland and duct
C69.51	Malignant neoplasm of right lacrimal gland and duct
C69.52	Malignant neoplasm of left lacrimal gland and duct
C69.60	Malignant neoplasm of unspecified orbit
C69.61	Malignant neoplasm of right orbit
C69.62	Malignant neoplasm of left orbit
C69.80	Malignant neoplasm of overlapping sites of unspecified eye and adnexa
C69.81	Malignant neoplasm of overlapping sites of right eye and adnexa
C69.82	Malignant neoplasm of overlapping sites of left eye and adnexa
C69.90	Malignant neoplasm of unspecified site of unspecified eye
C69.91	Malignant neoplasm of unspecified site of right eye
C69.92	Malignant neoplasm of unspecified site of left eye
C70.0	Malignant neoplasm of cerebral meninges
C70.1	Malignant neoplasm of spinal meninges
C70.9	Malignant neoplasm of meninges, unspecified
C71.0	Malignant neoplasm of cerebrum, except lobes and ventricles
C71.1	Malignant neoplasm of frontal lobe
C71.2	Malignant neoplasm of temporal lobe
C71.3	Malignant neoplasm of parietal lobe
C71.4	Malignant neoplasm of occipital lobe
C71.5	Malignant neoplasm of cerebral ventricle
C71.6	Malignant neoplasm of cerebellum
C71.7	Malignant neoplasm of brain stem
C71.8	Malignant neoplasm of overlapping sites of brain
C71.9	Malignant neoplasm of brain, unspecified
C72.0	Malignant neoplasm of spinal cord

C72.1	Malignant neoplasm of cauda equina
C72.20	Malignant neoplasm of unspecified olfactory nerve
C72.21	Malignant neoplasm of right olfactory nerve
C72.22	Malignant neoplasm of left olfactory nerve
C72.30	Malignant neoplasm of unspecified optic nerve
C72.31	Malignant neoplasm of right optic nerve
C72.32	Malignant neoplasm of left optic nerve
C72.40	Malignant neoplasm of unspecified acoustic nerve
C72.41	Malignant neoplasm of right acoustic nerve
C72.42	Malignant neoplasm of left acoustic nerve
C72.50	Malignant neoplasm of unspecified cranial nerve
C72.59	Malignant neoplasm of other cranial nerves
C72.9	Malignant neoplasm of central nervous system, unspecified
C73	Malignant neoplasm of thyroid gland
C74.00	Malignant neoplasm of cortex of unspecified adrenal gland
C74.01	Malignant neoplasm of cortex of right adrenal gland
C74.10	Malignant neoplasm of medulla of unspecified adrenal gland
C74.11	Malignant neoplasm of medulla of right adrenal gland
C74.12	Malignant neoplasm of medulla of left adrenal gland
C74.02	Malignant neoplasm of cortex of left adrenal gland
C74.90	Malignant neoplasm of unspecified part of unspecified adrenal gland
C74.91	Malignant neoplasm of unspecified part of right adrenal gland
C74.92	Malignant neoplasm of unspecified part of left adrenal gland
C75.0	Malignant neoplasm of parathyroid gland
C75.1	Malignant neoplasm of pituitary gland
C75.2	Malignant neoplasm of craniopharyngeal duct
C75.3	Malignant neoplasm of pineal gland
C75.4	Malignant neoplasm of carotid body
C75.5	Malignant neoplasm of aortic body and other paraganglia
C75.8	Malignant neoplasm with pluriglandular involvement, unspecified
C75.9	Malignant neoplasm of endocrine gland, unspecified
C76.0	Malignant neoplasm of head, face and neck
C76.1	Malignant neoplasm of thorax
C76.2	Malignant neoplasm of abdomen
C76.3	Malignant neoplasm of pelvis
C76.40	Malignant neoplasm of unspecified upper limb
C76.41	Malignant neoplasm of right upper limb
C76.42	Malignant neoplasm of left upper limb
C76.50	Malignant neoplasm of unspecified lower limb
C76.51	Malignant neoplasm of right lower limb
C76.52	Malignant neoplasm of left lower limb
C76.8	Malignant neoplasm of other specified ill-defined sites
C77.0	Secondary and unspecified malignant neoplasm of lymph nodes of head, face and neck
C77.1	Secondary and unspecified malignant neoplasm of intrathoracic lymph nodes

C77.2	Secondary and unspecified malignant neoplasm of intra-abdominal lymph nodes
C77.3	Secondary and unspecified malignant neoplasm of axilla and upper limb lymph nodes
C77.4	Secondary and unspecified malignant neoplasm of inguinal and lower limb lymph nodes
C77.5	Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes
C77.8	Secondary and unspecified malignant neoplasm of lymph nodes of multiple regions
C77.9	Secondary and unspecified malignant neoplasm of lymph node, unspecified
C78.00	Secondary malignant neoplasm of unspecified lung
C78.01	Secondary malignant neoplasm of right lung
C78.1	Secondary malignant neoplasm of mediastinum
C78.02	Secondary malignant neoplasm of left lung
C78.2	Secondary malignant neoplasm of pleura
C78.30	Secondary malignant neoplasm of unspecified respiratory organ
C78.39	Secondary malignant neoplasm of other respiratory organs
C78.4	Secondary malignant neoplasm of small intestine
C78.5	Secondary malignant neoplasm of large intestine and rectum
C78.6	Secondary malignant neoplasm of retroperitoneum and peritoneum
C78.7	Secondary malignant neoplasm of liver and intrahepatic bile duct
C78.80	Secondary malignant neoplasm of unspecified digestive organ
C78.89	Secondary malignant neoplasm of other digestive organs
C79.00	Secondary malignant neoplasm of unspecified kidney and renal pelvis
C79.01	Secondary malignant neoplasm of right kidney and renal pelvis
C79.10	Secondary malignant neoplasm of unspecified urinary organs
C79.11	Secondary malignant neoplasm of bladder
C79.19	Secondary malignant neoplasm of other urinary organs
C79.02	Secondary malignant neoplasm of left kidney and renal pelvis
C79.2	Secondary malignant neoplasm of skin
C79.31	Secondary malignant neoplasm of brain
C79.32	Secondary malignant neoplasm of cerebral meninges
C79.40	Secondary malignant neoplasm of unspecified part of nervous system
C79.49	Secondary malignant neoplasm of other parts of nervous system
C79.51	Secondary malignant neoplasm of bone
C79.52	Secondary malignant neoplasm of bone marrow
C79.60	Secondary malignant neoplasm of unspecified ovary
C79.61	Secondary malignant neoplasm of right ovary
C79.62	Secondary malignant neoplasm of left ovary
C79.63	Secondary malignant neoplasm of bilateral ovaries
C79.70	Secondary malignant neoplasm of unspecified adrenal gland
C79.71	Secondary malignant neoplasm of right adrenal gland
C79.72	Secondary malignant neoplasm of left adrenal gland
C79.81	Secondary malignant neoplasm of breast
C79.82	Secondary malignant neoplasm of genital organs
C79.89	Secondary malignant neoplasm of other specified sites
C79.9	Secondary malignant neoplasm of unspecified site
C7A.00	Malignant carcinoid tumor of unspecified site

C7A.1	Malignant poorly differentiated neuroendocrine tumors
C7A.010	Malignant carcinoid tumor of the duodenum
C7A.011	Malignant carcinoid tumor of the jejunum
C7A.012	Malignant carcinoid tumor of the ileum
C7A.019	Malignant carcinoid tumor of the small intestine, unspecified portion
C7A.020	Malignant carcinoid tumor of the appendix
C7A.021	Malignant carcinoid tumor of the cecum
C7A.022	Malignant carcinoid tumor of the ascending colon
C7A.023	Malignant carcinoid tumor of the transverse colon
C7A.024	Malignant carcinoid tumor of the descending colon
C7A.025	Malignant carcinoid tumor of the sigmoid colon
C7A.026	Malignant carcinoid tumor of the rectum
C7A.029	Malignant carcinoid tumor of the large intestine, unspecified portion
C7A.8	Other malignant neuroendocrine tumors
C7A.090	Malignant carcinoid tumor of the bronchus and lung
C7A.091	Malignant carcinoid tumor of the thymus
C7A.092	Malignant carcinoid tumor of the stomach
C7A.093	Malignant carcinoid tumor of the kidney
C7A.094	Malignant carcinoid tumor of the foregut, unspecified
C7A.095	Malignant carcinoid tumor of the midgut, unspecified
C7A.096	Malignant carcinoid tumor of the hindgut, unspecified
C7A.098	Malignant carcinoid tumors of other sites
C7B.00	Secondary carcinoid tumors, unspecified site
C7B.01	Secondary carcinoid tumors of distant lymph nodes
C7B.1	Secondary Merkel cell carcinoma
C7B.02	Secondary carcinoid tumors of liver
C7B.03	Secondary carcinoid tumors of bone
C7B.04	Secondary carcinoid tumors of peritoneum
C7B.8	Other secondary neuroendocrine tumors
C7B.09	Secondary carcinoid tumors of other sites
C80.0	Disseminated malignant neoplasm, unspecified
C80.1	Malignant (primary) neoplasm, unspecified
C80.2	Malignant neoplasm associated with transplanted organ
C81.00	Nodular lymphocyte predominant Hodgkin lymphoma, unspecified site
C81.01	Nodular lymphocyte predominant Hodgkin lymphoma, lymph nodes of head, face, and neck
C81.10	Nodular sclerosis Hodgkin lymphoma, unspecified site
C81.11	Nodular sclerosis Hodgkin lymphoma, lymph nodes of head, face, and neck
C81.12	Nodular sclerosis Hodgkin lymphoma, intrathoracic lymph nodes
C81.13	Nodular sclerosis Hodgkin lymphoma, intra-abdominal lymph nodes
C81.14	Nodular sclerosis Hodgkin lymphoma, lymph nodes of axilla and upper limb
C81.15	Nodular sclerosis Hodgkin lymphoma, lymph nodes of inguinal region and lower limb
C81.16	Nodular sclerosis Hodgkin lymphoma, intrapelvic lymph nodes
C81.17	Nodular sclerosis Hodgkin lymphoma, spleen
C81.18	Nodular sclerosis Hodgkin lymphoma, lymph nodes of multiple sites

C81.19	Nodular sclerosis Hodgkin lymphoma, extranodal and solid organ sites
C81.02	Nodular lymphocyte predominant Hodgkin lymphoma, intrathoracic lymph nodes
C81.20	Mixed cellularity Hodgkin lymphoma, unspecified site
C81.21	Mixed cellularity Hodgkin lymphoma, lymph nodes of head, face, and neck
C81.22	Mixed cellularity Hodgkin lymphoma, intrathoracic lymph nodes
C81.23	Mixed cellularity Hodgkin lymphoma, intra-abdominal lymph nodes
C81.24	Mixed cellularity Hodgkin lymphoma, lymph nodes of axilla and upper limb
C81.25	Mixed cellularity Hodgkin lymphoma, lymph nodes of inguinal region and lower limb
C81.26	Mixed cellularity Hodgkin lymphoma, intrapelvic lymph nodes
C81.27	Mixed cellularity Hodgkin lymphoma, spleen
C81.28	Mixed cellularity Hodgkin lymphoma, lymph nodes of multiple sites
C81.29	Mixed cellularity Hodgkin lymphoma, extranodal and solid organ sites
C81.03	Nodular lymphocyte predominant Hodgkin lymphoma, intra-abdominal lymph nodes
C81.30	Lymphocyte depleted Hodgkin lymphoma, unspecified site
C81.31	Lymphocyte depleted Hodgkin lymphoma, lymph nodes of head, face, and neck
C81.32	Lymphocyte depleted Hodgkin lymphoma, intrathoracic lymph nodes
C81.33	Lymphocyte depleted Hodgkin lymphoma, intra-abdominal lymph nodes
C81.34	Lymphocyte depleted Hodgkin lymphoma, lymph nodes of axilla and upper limb
C81.35	Lymphocyte depleted Hodgkin lymphoma, lymph nodes of inguinal region and lower limb
C81.36	Lymphocyte depleted Hodgkin lymphoma, intrapelvic lymph nodes
C81.37	Lymphocyte depleted Hodgkin lymphoma, spleen
C81.38	Lymphocyte depleted Hodgkin lymphoma, lymph nodes of multiple sites
C81.39	Lymphocyte depleted Hodgkin lymphoma, extranodal and solid organ sites
C81.04	Nodular lymphocyte predominant Hodgkin lymphoma, lymph nodes of axilla and upper limb
C81.40	Lymphocyte-rich Hodgkin lymphoma, unspecified site
C81.41	Lymphocyte-rich Hodgkin lymphoma, lymph nodes of head, face, and neck
C81.42	Lymphocyte-rich Hodgkin lymphoma, intrathoracic lymph nodes
C81.43	Lymphocyte-rich Hodgkin lymphoma, intra-abdominal lymph nodes
C81.44	Lymphocyte-rich Hodgkin lymphoma, lymph nodes of axilla and upper limb
C81.45	Lymphocyte-rich Hodgkin lymphoma, lymph nodes of inguinal region and lower limb
C81.46	Lymphocyte-rich Hodgkin lymphoma, intrapelvic lymph nodes
C81.47	Lymphocyte-rich Hodgkin lymphoma, spleen
C81.48	Lymphocyte-rich Hodgkin lymphoma, lymph nodes of multiple sites
C81.49	Lymphocyte-rich Hodgkin lymphoma, extranodal and solid organ sites
C81.05	Nodular lymphocyte predominant Hodgkin lymphoma, lymph nodes of inguinal region and lower limb
C81.06	Nodular lymphocyte predominant Hodgkin lymphoma, intrapelvic lymph nodes
C81.07	Nodular lymphocyte predominant Hodgkin lymphoma, spleen
C81.70	Other Hodgkin lymphoma, unspecified site
C81.71	Other Hodgkin lymphoma, lymph nodes of head, face, and neck
C81.72	Other Hodgkin lymphoma, intrathoracic lymph nodes
C81.73	Other Hodgkin lymphoma, intra-abdominal lymph nodes
C81.74	Other Hodgkin lymphoma, lymph nodes of axilla and upper limb
C81.75	Other Hodgkin lymphoma, lymph nodes of inguinal region and lower limb
C81.76	Other Hodgkin lymphoma, intrapelvic lymph nodes

C81.77	Other Hodgkin lymphoma, spleen
C81.78	Other Hodgkin lymphoma, lymph nodes of multiple sites
C81.79	Other Hodgkin lymphoma, extranodal and solid organ sites
C81.08	Nodular lymphocyte predominant Hodgkin lymphoma, lymph nodes of multiple sites
C81.09	Nodular lymphocyte predominant Hodgkin lymphoma, extranodal and solid organ sites
C81.90	Hodgkin lymphoma, unspecified, unspecified site
C81.91	Hodgkin lymphoma, unspecified, lymph nodes of head, face, and neck
C81.92	Hodgkin lymphoma, unspecified, intrathoracic lymph nodes
C81.93	Hodgkin lymphoma, unspecified, intra-abdominal lymph nodes
C81.94	Hodgkin lymphoma, unspecified, lymph nodes of axilla and upper limb
C81.95	Hodgkin lymphoma, unspecified, lymph nodes of inguinal region and lower limb
C81.96	Hodgkin lymphoma, unspecified, intrapelvic lymph nodes
C81.97	Hodgkin lymphoma, unspecified, spleen
C81.98	Hodgkin lymphoma, unspecified, lymph nodes of multiple sites
C81.99	Hodgkin lymphoma, unspecified, extranodal and solid organ sites
C82.00	Follicular lymphoma grade I, unspecified site
C82.01	Follicular lymphoma grade I, lymph nodes of head, face, and neck
C82.10	Follicular lymphoma grade II, unspecified site
C82.11	Follicular lymphoma grade II, lymph nodes of head, face, and neck
C82.12	Follicular lymphoma grade II, intrathoracic lymph nodes
C82.13	Follicular lymphoma grade II, intra-abdominal lymph nodes
C82.14	Follicular lymphoma grade II, lymph nodes of axilla and upper limb
C82.15	Follicular lymphoma grade II, lymph nodes of inguinal region and lower limb
C82.16	Follicular lymphoma grade II, intrapelvic lymph nodes
C82.17	Follicular lymphoma grade II, spleen
C82.18	Follicular lymphoma grade II, lymph nodes of multiple sites
C82.19	Follicular lymphoma grade II, extranodal and solid organ sites
C82.02	Follicular lymphoma grade I, intrathoracic lymph nodes
C82.20	Follicular lymphoma grade III, unspecified, unspecified site
C82.21	Follicular lymphoma grade III, unspecified, lymph nodes of head, face, and neck
C82.22	Follicular lymphoma grade III, unspecified, intrathoracic lymph nodes
C82.23	Follicular lymphoma grade III, unspecified, intra-abdominal lymph nodes
C82.24	Follicular lymphoma grade III, unspecified, lymph nodes of axilla and upper limb
C82.25	Follicular lymphoma grade III, unspecified, lymph nodes of inguinal region and lower limb
C82.26	Follicular lymphoma grade III, unspecified, intrapelvic lymph nodes
C82.27	Follicular lymphoma grade III, unspecified, spleen
C82.28	Follicular lymphoma grade III, unspecified, lymph nodes of multiple sites
C82.29	Follicular lymphoma grade III, unspecified, extranodal and solid organ sites
C82.03	Follicular lymphoma grade I, intra-abdominal lymph nodes
C82.30	Follicular lymphoma grade IIIa, unspecified site
C82.31	Follicular lymphoma grade IIIa, lymph nodes of head, face, and neck
C82.32	Follicular lymphoma grade IIIa, intrathoracic lymph nodes
C82.33	Follicular lymphoma grade IIIa, intra-abdominal lymph nodes
C82.34	Follicular lymphoma grade IIIa, lymph nodes of axilla and upper limb

C82.35	Follicular lymphoma grade IIIa, lymph nodes of inguinal region and lower limb
C82.36	Follicular lymphoma grade IIIa, intrapelvic lymph nodes
C82.37	Follicular lymphoma grade IIIa, spleen
C82.38	Follicular lymphoma grade IIIa, lymph nodes of multiple sites
C82.39	Follicular lymphoma grade IIIa, extranodal and solid organ sites
C82.04	Follicular lymphoma grade I, lymph nodes of axilla and upper limb
C82.40	Follicular lymphoma grade IIIb, unspecified site
C82.41	Follicular lymphoma grade IIIb, lymph nodes of head, face, and neck
C82.42	Follicular lymphoma grade IIIb, intrathoracic lymph nodes
C82.43	Follicular lymphoma grade IIIb, intra-abdominal lymph nodes
C82.44	Follicular lymphoma grade IIIb, lymph nodes of axilla and upper limb
C82.45	Follicular lymphoma grade IIIb, lymph nodes of inguinal region and lower limb
C82.46	Follicular lymphoma grade IIIb, intrapelvic lymph nodes
C82.47	Follicular lymphoma grade IIIb, spleen
C82.48	Follicular lymphoma grade IIIb, lymph nodes of multiple sites
C82.49	Follicular lymphoma grade IIIb, extranodal and solid organ sites
C82.05	Follicular lymphoma grade I, lymph nodes of inguinal region and lower limb
C82.50	Diffuse follicle center lymphoma, unspecified site
C82.51	Diffuse follicle center lymphoma, lymph nodes of head, face, and neck
C82.52	Diffuse follicle center lymphoma, intrathoracic lymph nodes
C82.53	Diffuse follicle center lymphoma, intra-abdominal lymph nodes
C82.54	Diffuse follicle center lymphoma, lymph nodes of axilla and upper limb
C82.55	Diffuse follicle center lymphoma, lymph nodes of inguinal region and lower limb
C82.56	Diffuse follicle center lymphoma, intrapelvic lymph nodes
C82.57	Diffuse follicle center lymphoma, spleen
C82.58	Diffuse follicle center lymphoma, lymph nodes of multiple sites
C82.59	Diffuse follicle center lymphoma, extranodal and solid organ sites
C82.06	Follicular lymphoma grade I, intrapelvic lymph nodes
C82.60	Cutaneous follicle center lymphoma, unspecified site
C82.61	Cutaneous follicle center lymphoma, lymph nodes of head, face, and neck
C82.62	Cutaneous follicle center lymphoma, intrathoracic lymph nodes
C82.63	Cutaneous follicle center lymphoma, intra-abdominal lymph nodes
C82.64	Cutaneous follicle center lymphoma, lymph nodes of axilla and upper limb
C82.65	Cutaneous follicle center lymphoma, lymph nodes of inguinal region and lower limb
C82.66	Cutaneous follicle center lymphoma, intrapelvic lymph nodes
C82.67	Cutaneous follicle center lymphoma, spleen
C82.68	Cutaneous follicle center lymphoma, lymph nodes of multiple sites
C82.69	Cutaneous follicle center lymphoma, extranodal and solid organ sites
C82.07	Follicular lymphoma grade I, spleen
C82.08	Follicular lymphoma grade I, lymph nodes of multiple sites
C82.80	Other types of follicular lymphoma, unspecified site
C82.81	Other types of follicular lymphoma, lymph nodes of head, face, and neck
C82.82	Other types of follicular lymphoma, intrathoracic lymph nodes
C82.83	Other types of follicular lymphoma, intra-abdominal lymph nodes

C82.84	Other types of follicular lymphoma, lymph nodes of axilla and upper limb
C82.85	Other types of follicular lymphoma, lymph nodes of inguinal region and lower limb
C82.86	Other types of follicular lymphoma, intrapelvic lymph nodes
C82.87	Other types of follicular lymphoma, spleen
C82.88	Other types of follicular lymphoma, lymph nodes of multiple sites
C82.89	Other types of follicular lymphoma, extranodal and solid organ sites
C82.09	Follicular lymphoma grade I, extranodal and solid organ sites
C82.90	Follicular lymphoma, unspecified, unspecified site
C82.91	Follicular lymphoma, unspecified, lymph nodes of head, face, and neck
C82.92	Follicular lymphoma, unspecified, intrathoracic lymph nodes
C82.93	Follicular lymphoma, unspecified, intra-abdominal lymph nodes
C82.94	Follicular lymphoma, unspecified, lymph nodes of axilla and upper limb
C82.95	Follicular lymphoma, unspecified, lymph nodes of inguinal region and lower limb
C82.96	Follicular lymphoma, unspecified, intrapelvic lymph nodes
C82.97	Follicular lymphoma, unspecified, spleen
C82.98	Follicular lymphoma, unspecified, lymph nodes of multiple sites
C82.99	Follicular lymphoma, unspecified, extranodal and solid organ sites
C83.00	Small cell B-cell lymphoma, unspecified site
C83.01	Small cell B-cell lymphoma, lymph nodes of head, face, and neck
C83.10	Mantle cell lymphoma, unspecified site
C83.11	Mantle cell lymphoma, lymph nodes of head, face, and neck
C83.12	Mantle cell lymphoma, intrathoracic lymph nodes
C83.13	Mantle cell lymphoma, intra-abdominal lymph nodes
C83.14	Mantle cell lymphoma, lymph nodes of axilla and upper limb
C83.15	Mantle cell lymphoma, lymph nodes of inguinal region and lower limb
C83.16	Mantle cell lymphoma, intrapelvic lymph nodes
C83.17	Mantle cell lymphoma, spleen
C83.18	Mantle cell lymphoma, lymph nodes of multiple sites
C83.19	Mantle cell lymphoma, extranodal and solid organ sites
C83.02	Small cell B-cell lymphoma, intrathoracic lymph nodes
C83.03	Small cell B-cell lymphoma, intra-abdominal lymph nodes
C83.30	Diffuse large B-cell lymphoma, unspecified site
C83.31	Diffuse large B-cell lymphoma, lymph nodes of head, face, and neck
C83.32	Diffuse large B-cell lymphoma, intrathoracic lymph nodes
C83.33	Diffuse large B-cell lymphoma, intra-abdominal lymph nodes
C83.34	Diffuse large B-cell lymphoma, lymph nodes of axilla and upper limb
C83.35	Diffuse large B-cell lymphoma, lymph nodes of inguinal region and lower limb
C83.36	Diffuse large B-cell lymphoma, intrapelvic lymph nodes
C83.37	Diffuse large B-cell lymphoma, spleen
C83.38	Diffuse large B-cell lymphoma, lymph nodes of multiple sites
C83.04	Small cell B-cell lymphoma, lymph nodes of axilla and upper limb
C83.05	Small cell B-cell lymphoma, lymph nodes of inguinal region and lower limb
C83.50	Lymphoblastic (diffuse) lymphoma, unspecified site
C83.51	Lymphoblastic (diffuse) lymphoma, lymph nodes of head, face, and neck

C83.52	Lymphoblastic (diffuse) lymphoma, intrathoracic lymph nodes
C83.53	Lymphoblastic (diffuse) lymphoma, intra-abdominal lymph nodes
C83.54	Lymphoblastic (diffuse) lymphoma, lymph nodes of axilla and upper limb
C83.55	Lymphoblastic (diffuse) lymphoma, lymph nodes of inguinal region and lower limb
C83.56	Lymphoblastic (diffuse) lymphoma, intrapelvic lymph nodes
C83.57	Lymphoblastic (diffuse) lymphoma, spleen
C83.58	Lymphoblastic (diffuse) lymphoma, lymph nodes of multiple sites
C83.59	Lymphoblastic (diffuse) lymphoma, extranodal and solid organ sites
C83.06	Small cell B-cell lymphoma, intrapelvic lymph nodes
C83.07	Small cell B-cell lymphoma, spleen
C83.70	Burkitt lymphoma, unspecified site
C83.71	Burkitt lymphoma, lymph nodes of head, face, and neck
C83.72	Burkitt lymphoma, intrathoracic lymph nodes
C83.73	Burkitt lymphoma, intra-abdominal lymph nodes
C83.74	Burkitt lymphoma, lymph nodes of axilla and upper limb
C83.75	Burkitt lymphoma, lymph nodes of inguinal region and lower limb
C83.76	Burkitt lymphoma, intrapelvic lymph nodes
C83.77	Burkitt lymphoma, spleen
C83.78	Burkitt lymphoma, lymph nodes of multiple sites
C83.79	Burkitt lymphoma, extranodal and solid organ sites
C83.08	Small cell B-cell lymphoma, lymph nodes of multiple sites
C83.80	Other non-follicular lymphoma, unspecified site
C83.81	Other non-follicular lymphoma, lymph nodes of head, face, and neck
C83.82	Other non-follicular lymphoma, intrathoracic lymph nodes
C83.83	Other non-follicular lymphoma, intra-abdominal lymph nodes
C83.84	Other non-follicular lymphoma, lymph nodes of axilla and upper limb
C83.85	Other non-follicular lymphoma, lymph nodes of inguinal region and lower limb
C83.86	Other non-follicular lymphoma, intrapelvic lymph nodes
C83.87	Other non-follicular lymphoma, spleen
C83.88	Other non-follicular lymphoma, lymph nodes of multiple sites
C83.89	Other non-follicular lymphoma, extranodal and solid organ sites
C83.09	Small cell B-cell lymphoma, extranodal and solid organ sites
C83.90	Non-follicular (diffuse) lymphoma, unspecified, unspecified site
C83.91	Non-follicular (diffuse) lymphoma, unspecified, lymph nodes of head, face, and neck
C83.92	Non-follicular (diffuse) lymphoma, unspecified, intrathoracic lymph nodes
C83.93	Non-follicular (diffuse) lymphoma, unspecified, intra-abdominal lymph nodes
C83.94	Non-follicular (diffuse) lymphoma, unspecified, lymph nodes of axilla and upper limb
C83.95	Non-follicular (diffuse) lymphoma, unspecified, lymph nodes of inguinal region and lower limb
C83.96	Non-follicular (diffuse) lymphoma, unspecified, intrapelvic lymph nodes
C83.97	Non-follicular (diffuse) lymphoma, unspecified, spleen
C83.98	Non-follicular (diffuse) lymphoma, unspecified, lymph nodes of multiple sites
C83.99	Non-follicular (diffuse) lymphoma, unspecified, extranodal and solid organ sites
C84.00	Mycosis fungoides, unspecified site
C84.01	Mycosis fungoides, lymph nodes of head, face, and neck

C84.10	Sezary disease, unspecified site
C84.11	Sezary disease, lymph nodes of head, face, and neck
C84.12	Sezary disease, intrathoracic lymph nodes
C84.13	Sezary disease, intra-abdominal lymph nodes
C84.14	Sezary disease, lymph nodes of axilla and upper limb
C84.15	Sezary disease, lymph nodes of inguinal region and lower limb
C84.16	Sezary disease, intrapelvic lymph nodes
C84.17	Sezary disease, spleen
C84.18	Sezary disease, lymph nodes of multiple sites
C84.19	Sezary disease, extranodal and solid organ sites
C84.02	Mycosis fungoides, intrathoracic lymph nodes
C84.03	Mycosis fungoides, intra-abdominal lymph nodes
C84.04	Mycosis fungoides, lymph nodes of axilla and upper limb
C84.40	Peripheral T-cell lymphoma, not elsewhere classified, unspecified site
C84.41	Peripheral T-cell lymphoma, not elsewhere classified, lymph nodes of head, face, and neck
C84.42	Peripheral T-cell lymphoma, not elsewhere classified, intrathoracic lymph nodes
C84.43	Peripheral T-cell lymphoma, not elsewhere classified, intra-abdominal lymph nodes
C84.44	Peripheral T-cell lymphoma, not elsewhere classified, lymph nodes of axilla and upper limb
C84.45	Peripheral T-cell lymphoma, not elsewhere classified, lymph nodes of inguinal region and lower limb
C84.46	Peripheral T-cell lymphoma, not elsewhere classified, intrapelvic lymph nodes
C84.47	Peripheral T-cell lymphoma, not elsewhere classified, spleen
C84.48	Peripheral T-cell lymphoma, not elsewhere classified, lymph nodes of multiple sites
C84.49	Peripheral T-cell lymphoma, not elsewhere classified, extranodal and solid organ sites
C84.05	Mycosis fungoides, lymph nodes of inguinal region and lower limb
C84.06	Mycosis fungoides, intrapelvic lymph nodes
C84.60	Anaplastic large cell lymphoma, ALK-positive, unspecified site
C84.61	Anaplastic large cell lymphoma, ALK-positive, lymph nodes of head, face, and neck
C84.62	Anaplastic large cell lymphoma, ALK-positive, intrathoracic lymph nodes
C84.63	Anaplastic large cell lymphoma, ALK-positive, intra-abdominal lymph nodes
C84.64	Anaplastic large cell lymphoma, ALK-positive, lymph nodes of axilla and upper limb
C84.65	Anaplastic large cell lymphoma, ALK-positive, lymph nodes of inguinal region and lower limb
C84.66	Anaplastic large cell lymphoma, ALK-positive, intrapelvic lymph nodes
C84.67	Anaplastic large cell lymphoma, ALK-positive, spleen
C84.68	Anaplastic large cell lymphoma, ALK-positive, lymph nodes of multiple sites
C84.69	Anaplastic large cell lymphoma, ALK-positive, extranodal and solid organ sites
C84.07	Mycosis fungoides, spleen
C84.70	Anaplastic large cell lymphoma, ALK-negative, unspecified site
C84.71	Anaplastic large cell lymphoma, ALK-negative, lymph nodes of head, face, and neck
C84.72	Anaplastic large cell lymphoma, ALK-negative, intrathoracic lymph nodes
C84.73	Anaplastic large cell lymphoma, ALK-negative, intra-abdominal lymph nodes
C84.74	Anaplastic large cell lymphoma, ALK-negative, lymph nodes of axilla and upper limb
C84.75	Anaplastic large cell lymphoma, ALK-negative, lymph nodes of inguinal region and lower limb
C84.76	Anaplastic large cell lymphoma, ALK-negative, intrapelvic lymph nodes

C84.77	Anaplastic large cell lymphoma, ALK-negative, spleen
C84.78	Anaplastic large cell lymphoma, ALK-negative, lymph nodes of multiple sites
C84.79	Anaplastic large cell lymphoma, ALK-negative, extranodal and solid organ sites
C84.7A	Anaplastic large cell lymphoma, ALK-negative, breast
C84.08	Mycosis fungoides, lymph nodes of multiple sites
C84.09	Mycosis fungoides, extranodal and solid organ sites
C84.90	Mature T/NK-cell lymphomas, unspecified, unspecified site
C84.91	Mature T/NK-cell lymphomas, unspecified, lymph nodes of head, face, and neck
C84.92	Mature T/NK-cell lymphomas, unspecified, intrathoracic lymph nodes
C84.93	Mature T/NK-cell lymphomas, unspecified, intra-abdominal lymph nodes
C84.94	Mature T/NK-cell lymphomas, unspecified, lymph nodes of axilla and upper limb
C84.95	Mature T/NK-cell lymphomas, unspecified, lymph nodes of inguinal region and lower limb
C84.96	Mature T/NK-cell lymphomas, unspecified, intrapelvic lymph nodes
C84.97	Mature T/NK-cell lymphomas, unspecified, spleen
C84.98	Mature T/NK-cell lymphomas, unspecified, lymph nodes of multiple sites
C84.99	Mature T/NK-cell lymphomas, unspecified, extranodal and solid organ sites
C84.A0	Cutaneous T-cell lymphoma, unspecified, unspecified site
C84.A1	Cutaneous T-cell lymphoma, unspecified lymph nodes of head, face, and neck
C84.A2	Cutaneous T-cell lymphoma, unspecified, intrathoracic lymph nodes
C84.A3	Cutaneous T-cell lymphoma, unspecified, intra-abdominal lymph nodes
C84.A4	Cutaneous T-cell lymphoma, unspecified, lymph nodes of axilla and upper limb
C84.A5	Cutaneous T-cell lymphoma, unspecified, lymph nodes of inguinal region and lower limb
C84.A6	Cutaneous T-cell lymphoma, unspecified, intrapelvic lymph nodes
C84.A7	Cutaneous T-cell lymphoma, unspecified, spleen
C84.A8	Cutaneous T-cell lymphoma, unspecified, lymph nodes of multiple sites
C84.A9	Cutaneous T-cell lymphoma, unspecified, extranodal and solid organ sites
C84.Z0	Other mature T/NK-cell lymphomas, unspecified site
C84.Z1	Other mature T/NK-cell lymphomas, lymph nodes of head, face, and neck
C84.Z2	Other mature T/NK-cell lymphomas, intrathoracic lymph nodes
C84.Z3	Other mature T/NK-cell lymphomas, intra-abdominal lymph nodes
C84.Z4	Other mature T/NK-cell lymphomas, lymph nodes of axilla and upper limb
C84.Z5	Other mature T/NK-cell lymphomas, lymph nodes of inguinal region and lower limb
C84.Z6	Other mature T/NK-cell lymphomas, intrapelvic lymph nodes
C84.Z7	Other mature T/NK-cell lymphomas, spleen
C84.Z8	Other mature T/NK-cell lymphomas, lymph nodes of multiple sites
C84.Z9	Other mature T/NK-cell lymphomas, extranodal and solid organ sites
C85.10	Unspecified B-cell lymphoma, unspecified site
C85.11	Unspecified B-cell lymphoma, lymph nodes of head, face, and neck
C85.12	Unspecified B-cell lymphoma, intrathoracic lymph nodes
C85.13	Unspecified B-cell lymphoma, intra-abdominal lymph nodes
C85.14	Unspecified B-cell lymphoma, lymph nodes of axilla and upper limb
C85.15	Unspecified B-cell lymphoma, lymph nodes of inguinal region and lower limb
C85.16	Unspecified B-cell lymphoma, intrapelvic lymph nodes
C85.17	Unspecified B-cell lymphoma, spleen

C85.18	Unspecified B-cell lymphoma, lymph nodes of multiple sites
C85.19	Unspecified B-cell lymphoma, extranodal and solid organ sites
C85.20	Mediastinal (thymic) large B-cell lymphoma, unspecified site
C85.21	Mediastinal (thymic) large B-cell lymphoma, lymph nodes of head, face, and neck
C85.22	Mediastinal (thymic) large B-cell lymphoma, intrathoracic lymph nodes
C85.23	Mediastinal (thymic) large B-cell lymphoma, intra-abdominal lymph nodes
C85.24	Mediastinal (thymic) large B-cell lymphoma, lymph nodes of axilla and upper limb
C85.25	Mediastinal (thymic) large B-cell lymphoma, lymph nodes of inguinal region and lower limb
C85.26	Mediastinal (thymic) large B-cell lymphoma, intrapelvic lymph nodes
C85.27	Mediastinal (thymic) large B-cell lymphoma, spleen
C85.28	Mediastinal (thymic) large B-cell lymphoma, lymph nodes of multiple sites
C85.29	Mediastinal (thymic) large B-cell lymphoma, extranodal and solid organ sites
C85.80	Other specified types of non-Hodgkin lymphoma, unspecified site
C85.81	Other specified types of non-Hodgkin lymphoma, lymph nodes of head, face, and neck
C85.82	Other specified types of non-Hodgkin lymphoma, intrathoracic lymph nodes
C85.83	Other specified types of non-Hodgkin lymphoma, intra-abdominal lymph nodes
C85.84	Other specified types of non-Hodgkin lymphoma, lymph nodes of axilla and upper limb
C85.85	Other specified types of non-Hodgkin lymphoma, lymph nodes of inguinal region and lower limb
C85.86	Other specified types of non-Hodgkin lymphoma, intrapelvic lymph nodes
C85.87	Other specified types of non-Hodgkin lymphoma, spleen
C85.88	Other specified types of non-Hodgkin lymphoma, lymph nodes of multiple sites
C85.89	Other specified types of non-Hodgkin lymphoma, extranodal and solid organ sites
C85.90	Non-Hodgkin lymphoma, unspecified, unspecified site
C85.91	Non-Hodgkin lymphoma, unspecified, lymph nodes of head, face, and neck
C85.92	Non-Hodgkin lymphoma, unspecified, intrathoracic lymph nodes
C85.93	Non-Hodgkin lymphoma, unspecified, intra-abdominal lymph nodes
C85.94	Non-Hodgkin lymphoma, unspecified, lymph nodes of axilla and upper limb
C85.95	Non-Hodgkin lymphoma, unspecified, lymph nodes of inguinal region and lower limb
C85.96	Non-Hodgkin lymphoma, unspecified, intrapelvic lymph nodes
C85.97	Non-Hodgkin lymphoma, unspecified, spleen
C85.98	Non-Hodgkin lymphoma, unspecified, lymph nodes of multiple sites
C85.99	Non-Hodgkin lymphoma, unspecified, extranodal and solid organ sites
C90.00	Multiple myeloma not having achieved remission
C90.01	Multiple myeloma in remission
C90.10	Plasma cell leukemia not having achieved remission
C90.11	Plasma cell leukemia in remission
C90.12	Plasma cell leukemia in relapse
C90.02	Multiple myeloma in relapse
C90.20	Extramedullary plasmacytoma not having achieved remission
C90.21	Extramedullary plasmacytoma in remission
C90.22	Extramedullary plasmacytoma in relapse
C90.30	Solitary plasmacytoma not having achieved remission
C90.31	Solitary plasmacytoma in remission
C90.32	Solitary plasmacytoma in relapse

C91.00	Acute lymphoblastic leukemia not having achieved remission
C91.01	Acute lymphoblastic leukemia, in remission
C91.10	Chronic lymphocytic leukemia of B-cell type not having achieved remission
C91.11	Chronic lymphocytic leukemia of B-cell type in remission
C91.12	Chronic lymphocytic leukemia of B-cell type in relapse
C91.02	Acute lymphoblastic leukemia, in relapse
C91.30	Prolymphocytic leukemia of B-cell type not having achieved remission
C91.31	Prolymphocytic leukemia of B-cell type, in remission
C91.32	Prolymphocytic leukemia of B-cell type, in relapse
C91.40	Hairy cell leukemia not having achieved remission
C91.41	Hairy cell leukemia, in remission
C91.42	Hairy cell leukemia, in relapse
C91.50	Adult T-cell lymphoma/leukemia (HTLV-1-associated) not having achieved remission
C91.51	Adult T-cell lymphoma/leukemia (HTLV-1-associated), in remission
C91.52	Adult T-cell lymphoma/leukemia (HTLV-1-associated), in relapse
C91.60	Prolymphocytic leukemia of T-cell type not having achieved remission
C91.61	Prolymphocytic leukemia of T-cell type, in remission
C91.62	Prolymphocytic leukemia of T-cell type, in relapse
C91.90	Lymphoid leukemia, unspecified not having achieved remission
C91.91	Lymphoid leukemia, unspecified, in remission
C91.92	Lymphoid leukemia, unspecified, in relapse
C91.A0	Mature B-cell leukemia Burkitt-type not having achieved remission
C91.A1	Mature B-cell leukemia Burkitt-type, in remission
C91.A2	Mature B-cell leukemia Burkitt-type, in relapse
C91.Z0	Other lymphoid leukemia not having achieved remission
C91.Z1	Other lymphoid leukemia, in remission
C91.Z2	Other lymphoid leukemia, in relapse
C92.00	Acute myeloblastic leukemia, not having achieved remission
C92.01	Acute myeloblastic leukemia, in remission
C92.10	Chronic myeloid leukemia, BCR/ABL-positive, not having achieved remission
C92.11	Chronic myeloid leukemia, BCR/ABL-positive, in remission
C92.12	Chronic myeloid leukemia, BCR/ABL-positive, in relapse
C92.02	Acute myeloblastic leukemia, in relapse
C92.20	Atypical chronic myeloid leukemia, BCR/ABL-negative, not having achieved remission
C92.21	Atypical chronic myeloid leukemia, BCR/ABL-negative, in remission
C92.22	Atypical chronic myeloid leukemia, BCR/ABL-negative, in relapse
C92.30	Myeloid sarcoma, not having achieved remission
C92.31	Myeloid sarcoma, in remission
C92.32	Myeloid sarcoma, in relapse
C92.40	Acute promyelocytic leukemia, not having achieved remission
C92.41	Acute promyelocytic leukemia, in remission
C92.42	Acute promyelocytic leukemia, in relapse
C92.50	Acute myelomonocytic leukemia, not having achieved remission
C92.51	Acute myelomonocytic leukemia, in remission

C92.52	Acute myelomonocytic leukemia, in relapse
C92.60	Acute myeloid leukemia with 11q23-abnormality not having achieved remission
C92.61	Acute myeloid leukemia with 11q23-abnormality in remission
C92.62	Acute myeloid leukemia with 11q23-abnormality in relapse
C92.90	Myeloid leukemia, unspecified, not having achieved remission
C92.91	Myeloid leukemia, unspecified in remission
C92.92	Myeloid leukemia, unspecified in relapse
C92.A0	Acute myeloid leukemia with multilineage dysplasia, not having achieved remission
C92.A1	Acute myeloid leukemia with multilineage dysplasia, in remission
C92.A2	Acute myeloid leukemia with multilineage dysplasia, in relapse
C92.Z0	Other myeloid leukemia not having achieved remission
C92.Z1	Other myeloid leukemia, in remission
C92.Z2	Other myeloid leukemia, in relapse
C93.00	Acute monoblastic/monocytic leukemia, not having achieved remission
C93.01	Acute monoblastic/monocytic leukemia, in remission
C93.10	Chronic myelomonocytic leukemia not having achieved remission
C93.11	Chronic myelomonocytic leukemia, in remission
C93.12	Chronic myelomonocytic leukemia, in relapse
C93.02	Acute monoblastic/monocytic leukemia, in relapse
C93.30	Juvenile myelomonocytic leukemia, not having achieved remission
C93.31	Juvenile myelomonocytic leukemia, in remission
C93.32	Juvenile myelomonocytic leukemia, in relapse
C93.90	Monocytic leukemia, unspecified, not having achieved remission
C93.91	Monocytic leukemia, unspecified in remission
C93.92	Monocytic leukemia, unspecified in relapse
C93.Z0	Other monocytic leukemia, not having achieved remission
C93.Z1	Other monocytic leukemia, in remission
C93.Z2	Other monocytic leukemia, in relapse
C94.00	Acute erythroid leukemia, not having achieved remission
C94.01	Acute erythroid leukemia, in remission
C94.02	Acute erythroid leukemia, in relapse
C94.20	Acute megakaryoblastic leukemia not having achieved remission
C94.21	Acute megakaryoblastic leukemia, in remission
C94.22	Acute megakaryoblastic leukemia, in relapse
C94.30	Mast cell leukemia not having achieved remission
C94.31	Mast cell leukemia, in remission
C94.32	Mast cell leukemia, in relapse
C94.40	Acute panmyelosis with myelofibrosis not having achieved remission
C94.41	Acute panmyelosis with myelofibrosis, in remission
C94.42	Acute panmyelosis with myelofibrosis, in relapse
C94.6	Myelodysplastic disease, not elsewhere classified
C94.80	Other specified leukemias not having achieved remission
C94.81	Other specified leukemias, in remission
C94.82	Other specified leukemias, in relapse

C95.00	Acute leukemia of unspecified cell type not having achieved remission
C95.01	Acute leukemia of unspecified cell type, in remission
C95.10	Chronic leukemia of unspecified cell type not having achieved remission
C95.11	Chronic leukemia of unspecified cell type, in remission
C95.12	Chronic leukemia of unspecified cell type, in relapse
C95.02	Acute leukemia of unspecified cell type, in relapse
C95.90	Leukemia, unspecified not having achieved remission
C95.91	Leukemia, unspecified, in remission
C95.92	Leukemia, unspecified, in relapse
C96.0	Multifocal and multisystemic (disseminated) Langerhans-cell histiocytosis
C96.20	Malignant mast cell neoplasm, unspecified
C96.21	Aggressive systemic mastocytosis
C96.22	Mast cell sarcoma
C96.29	Other malignant mast cell neoplasm
C96.4	Sarcoma of dendritic cells (accessory cells)
C96.5	Multifocal and unisystemic Langerhans-cell histiocytosis
C96.6	Unifocal Langerhans-cell histiocytosis
C96.9	Malignant neoplasm of lymphoid, hematopoietic and related tissue, unspecified
C96.A	Histiocytic sarcoma
C96.Z	Other specified malignant neoplasms of lymphoid, hematopoietic and related tissue
D00.00	Carcinoma in situ of oral cavity, unspecified site
D00.01	Carcinoma in situ of labial mucosa and vermilion border
D00.1	Carcinoma in situ of esophagus
D00.02	Carcinoma in situ of buccal mucosa
D00.2	Carcinoma in situ of stomach
D00.03	Carcinoma in situ of gingiva and edentulous alveolar ridge
D00.04	Carcinoma in situ of soft palate
D00.05	Carcinoma in situ of hard palate
D00.06	Carcinoma in situ of floor of mouth
D00.07	Carcinoma in situ of tongue
D00.08	Carcinoma in situ of pharynx
D01.0	Carcinoma in situ of colon
D01.1	Carcinoma in situ of rectosigmoid junction
D01.2	Carcinoma in situ of rectum
D01.3	Carcinoma in situ of anus and anal canal
D01.40	Carcinoma in situ of unspecified part of intestine
D01.49	Carcinoma in situ of other parts of intestine
D01.5	Carcinoma in situ of liver, gallbladder and bile ducts
D01.7	Carcinoma in situ of other specified digestive organs
D01.9	Carcinoma in situ of digestive organ, unspecified
D02.0	Carcinoma in situ of larynx
D02.1	Carcinoma in situ of trachea
D02.20	Carcinoma in situ of unspecified bronchus and lung
D02.21	Carcinoma in situ of right bronchus and lung

D02.22	Carcinoma in situ of left bronchus and lung
D02.3	Carcinoma in situ of other parts of respiratory system
D02.4	Carcinoma in situ of respiratory system, unspecified
D03.0	Melanoma in situ of lip
D03.10	Melanoma in situ of unspecified eyelid, including canthus
D03.111	Melanoma in situ of right upper eyelid, including canthus
D03.112	Melanoma in situ of right lower eyelid, including canthus
D03.121	Melanoma in situ of left upper eyelid, including canthus
D03.122	Melanoma in situ of left lower eyelid, including canthus
D03.20	Melanoma in situ of unspecified ear and external auricular canal
D03.21	Melanoma in situ of right ear and external auricular canal
D03.22	Melanoma in situ of left ear and external auricular canal
D03.30	Melanoma in situ of unspecified part of face
D03.39	Melanoma in situ of other parts of face
D03.4	Melanoma in situ of scalp and neck
D03.51	Melanoma in situ of anal skin
D03.52	Melanoma in situ of breast (skin) (soft tissue)
D03.59	Melanoma in situ of other part of trunk
D03.60	Melanoma in situ of unspecified upper limb, including shoulder
D03.61	Melanoma in situ of right upper limb, including shoulder
D03.62	Melanoma in situ of left upper limb, including shoulder
D03.70	Melanoma in situ of unspecified lower limb, including hip
D03.71	Melanoma in situ of right lower limb, including hip
D03.72	Melanoma in situ of left lower limb, including hip
D03.8	Melanoma in situ of other sites
D03.9	Melanoma in situ, unspecified
D04.0	Carcinoma in situ of skin of lip
D04.10	Carcinoma in situ of skin of unspecified eyelid, including canthus
D04.111	Carcinoma in situ of skin of right upper eyelid, including canthus
D04.112	Carcinoma in situ of skin of right lower eyelid, including canthus
D04.121	Carcinoma in situ of skin of left upper eyelid, including canthus
D04.122	Carcinoma in situ of skin of left lower eyelid, including canthus
D04.20	Carcinoma in situ of skin of unspecified ear and external auricular canal
D04.21	Carcinoma in situ of skin of right ear and external auricular canal
D04.22	Carcinoma in situ of skin of left ear and external auricular canal
D04.30	Carcinoma in situ of skin of unspecified part of face
D04.39	Carcinoma in situ of skin of other parts of face
D04.4	Carcinoma in situ of skin of scalp and neck
D04.5	Carcinoma in situ of skin of trunk
D04.60	Carcinoma in situ of skin of unspecified upper limb, including shoulder
D04.61	Carcinoma in situ of skin of right upper limb, including shoulder
D04.62	Carcinoma in situ of skin of left upper limb, including shoulder
D04.70	Carcinoma in situ of skin of unspecified lower limb, including hip
D04.71	Carcinoma in situ of skin of right lower limb, including hip

D04.72	Carcinoma in situ of skin of left lower limb, including hip
D04.8	Carcinoma in situ of skin of other sites
D04.9	Carcinoma in situ of skin, unspecified
D05.00	Lobular carcinoma in situ of unspecified breast
D05.01	Lobular carcinoma in situ of right breast
D05.10	Intraductal carcinoma in situ of unspecified breast
D05.11	Intraductal carcinoma in situ of right breast
D05.12	Intraductal carcinoma in situ of left breast
D05.02	Lobular carcinoma in situ of left breast
D05.80	Other specified type of carcinoma in situ of unspecified breast
D05.81	Other specified type of carcinoma in situ of right breast
D05.82	Other specified type of carcinoma in situ of left breast
D05.90	Unspecified type of carcinoma in situ of unspecified breast
D05.91	Unspecified type of carcinoma in situ of right breast
D05.92	Unspecified type of carcinoma in situ of left breast
D06.0	Carcinoma in situ of endocervix
D06.1	Carcinoma in situ of exocervix
D06.7	Carcinoma in situ of other parts of cervix
D06.9	Carcinoma in situ of cervix, unspecified
D07.0	Carcinoma in situ of endometrium
D07.1	Carcinoma in situ of vulva
D07.2	Carcinoma in situ of vagina
D07.30	Carcinoma in situ of unspecified female genital organs
D07.39	Carcinoma in situ of other female genital organs
D07.4	Carcinoma in situ of penis
D07.5	Carcinoma in situ of prostate
D07.60	Carcinoma in situ of unspecified male genital organs
D07.61	Carcinoma in situ of scrotum
D07.69	Carcinoma in situ of other male genital organs
D09.0	Carcinoma in situ of bladder
D09.10	Carcinoma in situ of unspecified urinary organ
D09.19	Carcinoma in situ of other urinary organs
D09.20	Carcinoma in situ of unspecified eye
D09.21	Carcinoma in situ of right eye
D09.22	Carcinoma in situ of left eye
D09.3	Carcinoma in situ of thyroid and other endocrine glands
D09.8	Carcinoma in situ of other specified sites
D09.9	Carcinoma in situ, unspecified
C81.0A	Nodular lymphocyte predominant Hodgkin lymphoma, in remission
C81.1A	Nodular sclerosis Hodgkin lymphoma, in remission
C81.2A	Mixed cellularity Hodgkin lymphoma, in remission
C81.3A	Lymphocyte depleted Hodgkin lymphoma, in remission
C81.4A	Lymphocyte-rich Hodgkin lymphoma, in remission
C81.7A	Other Hodgkin lymphoma, in remission

C81.9A	Hodgkin lymphoma, unspecified, in remission
C82.0A	Follicular lymphoma grade I, in remission
C82.1A	Follicular lymphoma grade II, in remission
C82.2A	Follicular lymphoma grade III, unspecified, in remission
C82.3A	Follicular lymphoma grade IIIa, in remission
C82.4A	Follicular lymphoma grade IIIb, in remission
C82.5A	Diffuse follicle center lymphoma, in remission
C82.6A	Cutaneous follicle center lymphoma, in remission
C82.8A	Other types of follicular lymphoma, in remission
C82.9A	Follicular lymphoma, unspecified, in remission
C83.0A	Small cell B-cell lymphoma, in remission
C83.1A	Mantle cell lymphoma, in remission
C83.390	Primary central nervous system lymphoma
C83.398	Diffuse large B-cell lymphoma of other extranodal and solid organ sites
C83.3A	Diffuse large B-cell lymphoma, in remission
C83.5A	Lymphoblastic (diffuse) lymphoma, in remission
C83.7A	Burkitt lymphoma, in remission
C83.8A	Other non-follicular lymphoma, in remission
C83.9A	Non-follicular (diffuse) lymphoma, unspecified, in remission
C84.0A	Mycosis fungoides, in remission
C84.1A	Sezary disease, in remission
C84.4A	Peripheral T-cell lymphoma, not elsewhere classified, in remission
C84.6A	Anaplastic large cell lymphoma, ALK-positive, in remission
C84.7B	Anaplastic large cell lymphoma, ALK-negative, in remission
C84.9A	Mature T/NK-cell lymphomas, unspecified, in remission
C84.AA	Cutaneous T-cell lymphoma, unspecified, in remission
C84.ZA	Other mature T/NK-cell lymphomas, in remission
C85.1A	Unspecified B-cell lymphoma, in remission
C85.2A	Mediastinal (thymic) large B-cell lymphoma, in remission
C85.8A	Other specified types of non-Hodgkin lymphoma, in remission
C85.9A	Non-Hodgkin lymphoma, unspecified, in remission
C86.00	Extranodal NK/T-cell lymphoma, nasal type not having achieved remission
C86.01	Extranodal NK/T-cell lymphoma, nasal type, in remission
C86.10	Hepatosplenic T-cell lymphoma not having achieved remission
C86.11	Hepatosplenic T-cell lymphoma, in remission
C86.20	Enteropathy-type (intestinal) T-cell lymphoma not having achieved remission
C86.21	Enteropathy-type (intestinal) T-cell lymphoma, in remission
C86.30	Subcutaneous panniculitis-like T-cell lymphoma not having achieved remission
C86.31	Subcutaneous panniculitis-like T-cell lymphoma, in remission
C86.40	Blastic NK-cell lymphoma not having achieved remission
C86.41	Blastic NK-cell lymphoma, in remission
C86.50	Angioimmunoblastic T-cell lymphoma not having achieved remission
C86.51	Angioimmunoblastic T-cell lymphoma, in remission
C86.60	Primary cutaneous CD30-positive T-cell proliferations not having achieved remission

C86.61	Primary cutaneous CD30-positive T-cell proliferations, in remission
C88.00	Waldenstrom macroglobulinemia not having achieved remission
C88.01	Waldenstrom macroglobulinemia, in remission
C88.20	Heavy chain disease not having achieved remission
C88.21	Heavy chain disease, in remission
C88.30	Immunoproliferative small intestinal disease not having achieved remission
C88.31	Immunoproliferative small intestinal disease, in remission
C88.40	Extranodal marginal zone B-cell lymphoma of mucosa-associated lymphoid tissue [MALT-lymphoma] not having achieved remission
C88.41	Extranodal marginal zone B-cell lymphoma of mucosa-associated lymphoid tissue [MALT-lymphoma], in remission
C88.80	Other malignant immunoproliferative diseases not having achieved remission
C88.81	Other malignant immunoproliferative diseases, in remission
C88.90	Malignant immunoproliferative disease, unspecified not having achieved remission
C88.91	Malignant immunoproliferative disease, unspecified, in remission
E34.00	Carcinoid syndrome, unspecified
E34.01	Carcinoid heart syndrome
E34.09	Other carcinoid syndrome

Breast Cancer Dx Codes	Descriptions
C50.011	Malignant neoplasm of nipple and areola, right female breast
C50.111	Malignant neoplasm of central portion of right female breast
C50.112	Malignant neoplasm of central portion of left female breast
C50.119	Malignant neoplasm of central portion of unspecified female breast
C50.012	Malignant neoplasm of nipple and areola, left female breast
C50.121	Malignant neoplasm of central portion of right male breast
C50.122	Malignant neoplasm of central portion of left male breast
C50.129	Malignant neoplasm of central portion of unspecified male breast
C50.019	Malignant neoplasm of nipple and areola, unspecified female breast
C50.021	Malignant neoplasm of nipple and areola, right male breast
C50.211	Malignant neoplasm of upper-inner quadrant of right female breast
C50.212	Malignant neoplasm of upper-inner quadrant of left female breast
C50.219	Malignant neoplasm of upper-inner quadrant of unspecified female breast
C50.022	Malignant neoplasm of nipple and areola, left male breast
C50.221	Malignant neoplasm of upper-inner quadrant of right male breast
C50.222	Malignant neoplasm of upper-inner quadrant of left male breast
C50.229	Malignant neoplasm of upper-inner quadrant of unspecified male breast
C50.029	Malignant neoplasm of nipple and areola, unspecified male breast
C50.311	Malignant neoplasm of lower-inner quadrant of right female breast
C50.312	Malignant neoplasm of lower-inner quadrant of left female breast
C50.319	Malignant neoplasm of lower-inner quadrant of unspecified female breast
C50.321	Malignant neoplasm of lower-inner quadrant of right male breast
C50.322	Malignant neoplasm of lower-inner quadrant of left male breast

C50.329	Malignant neoplasm of lower-inner quadrant of unspecified male breast
C50.411	Malignant neoplasm of upper-outer quadrant of right female breast
C50.412	Malignant neoplasm of upper-outer quadrant of left female breast
C50.419	Malignant neoplasm of upper-outer quadrant of unspecified female breast
C50.421	Malignant neoplasm of upper-outer quadrant of right male breast
C50.422	Malignant neoplasm of upper-outer quadrant of left male breast
C50.429	Malignant neoplasm of upper-outer quadrant of unspecified male breast
C50.511	Malignant neoplasm of lower-outer quadrant of right female breast
C50.512	Malignant neoplasm of lower-outer quadrant of left female breast
C50.519	Malignant neoplasm of lower-outer quadrant of unspecified female breast
C50.521	Malignant neoplasm of lower-outer quadrant of right male breast
C50.522	Malignant neoplasm of lower-outer quadrant of left male breast
C50.529	Malignant neoplasm of lower-outer quadrant of unspecified male breast
C50.611	Malignant neoplasm of axillary tail of right female breast
C50.612	Malignant neoplasm of axillary tail of left female breast
C50.619	Malignant neoplasm of axillary tail of unspecified female breast
C50.621	Malignant neoplasm of axillary tail of right male breast
C50.622	Malignant neoplasm of axillary tail of left male breast
C50.629	Malignant neoplasm of axillary tail of unspecified male breast
C50.811	Malignant neoplasm of overlapping sites of right female breast
C50.812	Malignant neoplasm of overlapping sites of left female breast
C50.819	Malignant neoplasm of overlapping sites of unspecified female breast
C50.821	Malignant neoplasm of overlapping sites of right male breast
C50.822	Malignant neoplasm of overlapping sites of left male breast
C50.829	Malignant neoplasm of overlapping sites of unspecified male breast
C50.911	Malignant neoplasm of unspecified site of right female breast
C50.912	Malignant neoplasm of unspecified site of left female breast
C50.919	Malignant neoplasm of unspecified site of unspecified female breast
C50.921	Malignant neoplasm of unspecified site of right male breast
C50.922	Malignant neoplasm of unspecified site of left male breast
C50.929	Malignant neoplasm of unspecified site of unspecified male breast
Z85.3	Personal history of malignant neoplasm of breast
C79.81	Secondary malignant neoplasm of breast
C84.7A	Anaplastic large cell lymphoma, ALK-negative, breast
D05.00	Lobular carcinoma in situ of unspecified breast
D05.01	Lobular carcinoma in situ of right breast
D05.10	Intraductal carcinoma in situ of unspecified breast
D05.11	Intraductal carcinoma in situ of right breast
D05.12	Intraductal carcinoma in situ of left breast
D05.02	Lobular carcinoma in situ of left breast
D05.80	Other specified type of carcinoma in situ of unspecified breast
D05.81	Other specified type of carcinoma in situ of right breast
D05.82	Other specified type of carcinoma in situ of left breast
D05.90	Unspecified type of carcinoma in situ of unspecified breast

D05.91	Unspecified type of carcinoma in situ of right breast
D05.92	Unspecified type of carcinoma in situ of left breast

Intraocular Injectio	Descriptions
B39.4	Histoplasmosis capsulati, unspecified
B39.5	Histoplasmosis duboisii
B39.9	Histoplasmosis, unspecified
E08.311	Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy with macular edema
E08.319	Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy without macular edema
E08.3211	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema, right eye
E08.3212	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema, left eye
E08.3213	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema, bilateral
E08.3219	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema, unspecified eye
E08.3291	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema, right eye
E08.3292	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema, left eye
E08.3293	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema, bilateral
E08.3299	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema, unspecified eye
E08.3311	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema, right eye
E08.3312	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema, left eye
E08.3313	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema, bilateral
E08.3319	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema, unspecified eye
E08.3391	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema, right eye
E08.3392	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema, left eye
E08.3393	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema, bilateral
E08.3399	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema, unspecified eye
E08.3411	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema, right eye
E08.3412	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema, left eye
E08.3413	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema, bilateral
E08.3419	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema, unspecified eye
E08.3491	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema, right eye
E08.3492	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema, left eye
E08.3493	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema, bilateral
E08.3499	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema, unspecified eye
E08.3511	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, right eye
E08.3512	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, left eye
E08.3513	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, bilateral
E08.3519	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema, unspecified eye
E08.3521	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye
E08.3522	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye
E08.3523	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral
E08.3529	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment involving the macula, unspecified eye
E08.3531	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye
E08.3532	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye
E08.3533	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral

E08.3539	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, unspecified eye
E08.3541	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye
E08.3542	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye
E08.3543	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral
E08.3549	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, unspecified eye
E08.3551	Diabetes mellitus due to underlying condition with stable proliferative diabetic retinopathy, right eye
E08.3552	Diabetes mellitus due to underlying condition with stable proliferative diabetic retinopathy, left eye
E08.3553	Diabetes mellitus due to underlying condition with stable proliferative diabetic retinopathy, bilateral
E08.3559	Diabetes mellitus due to underlying condition with stable proliferative diabetic retinopathy, unspecified eye
E08.3591	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, right eye
E08.3592	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, left eye
E08.3593	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, bilateral
E08.3599	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema, unspecified eye
E08.37X1	Diabetes mellitus due to underlying condition with diabetic macular edema, resolved following treatment, right eye
E08.37X2	Diabetes mellitus due to underlying condition with diabetic macular edema, resolved following treatment, left eye
E08.37X3	Diabetes mellitus due to underlying condition with diabetic macular edema, resolved following treatment, bilateral
E09.311	Drug or chemical induced diabetes mellitus with unspecified diabetic retinopathy with macular edema
E09.319	Drug or chemical induced diabetes mellitus with unspecified diabetic retinopathy without macular edema
E09.3211	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye
E09.3212	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye
E09.3213	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral
E09.3219	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, unspecified eye
E09.3291	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye
E09.3292	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye
E09.3293	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral
E09.3299	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, unspecified eye
E09.3311	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye
E09.3312	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye
E09.3313	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral
E09.3319	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, unspecified eye
E09.3391	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye
E09.3392	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye
E09.3393	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral
E09.3399	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, unspecified eye
E09.3411	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye
E09.3412	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye
E09.3413	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral
E09.3419	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, unspecified eye
E09.3491	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye
E09.3492	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye
E09.3493	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral
E09.3499	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, unspecified eye
E09.3511	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye
E09.3512	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye

E09.3513	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral
E09.3519	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema, unspecified eye
E09.3521	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye
E09.3522	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye
E09.3523	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral
E09.3529	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, unspecified eye
E09.3531	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye
E09.3532	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye
E09.3533	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral
E09.3539	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, unspecified eye
E09.3541	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye
E09.3542	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye
E09.3543	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral
E09.3549	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, unspecified eye
E09.3551	Drug or chemical induced diabetes mellitus with stable proliferative diabetic retinopathy, right eye
E09.3552	Drug or chemical induced diabetes mellitus with stable proliferative diabetic retinopathy, left eye
E09.3553	Drug or chemical induced diabetes mellitus with stable proliferative diabetic retinopathy, bilateral
E09.3559	Drug or chemical induced diabetes mellitus with stable proliferative diabetic retinopathy, unspecified eye
E09.3591	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye
E09.3592	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye
E09.3593	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral
E09.3599	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema, unspecified eye
E09.37X1	Drug or chemical induced diabetes mellitus with diabetic macular edema, resolved following treatment, right eye
E09.37X2	Drug or chemical induced diabetes mellitus with diabetic macular edema, resolved following treatment, left eye
E09.37X3	Drug or chemical induced diabetes mellitus with diabetic macular edema, resolved following treatment, bilateral
E10.311	Type 1 diabetes mellitus with unspecified diabetic retinopathy with macular edema
E10.319	Type 1 diabetes mellitus with unspecified diabetic retinopathy without macular edema
E10.3211	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye
E10.3212	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye
E10.3213	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral
E10.3219	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, unspecified eye
E10.3291	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye
E10.3292	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye
E10.3293	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral
E10.3299	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, unspecified eye
E10.3311	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye
E10.3312	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye
E10.3313	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral
E10.3319	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, unspecified eye
E10.3391	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye
E10.3392	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye
E10.3393	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral
E10.3399	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, unspecified eye
E10.3411	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye

E10.3412	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye
E10.3413	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral
E10.3419	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, unspecified eye
E10.3491	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye
E10.3492	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye
E10.3493	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral
E10.3499	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, unspecified eye
E10.3511	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye
E10.3512	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye
E10.3513	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral
E10.3519	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, unspecified eye
E10.3521	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye
E10.3522	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye
E10.3523	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral
E10.3529	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, unspecified eye
E10.3531	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye
E10.3532	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye
E10.3533	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral
E10.3539	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, unspecified eye
E10.3541	Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye
E10.3542	Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye
E10.3543	Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral
E10.3549	Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, unspecified eye
E10.3551	Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, right eye
E10.3552	Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, left eye
E10.3553	Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, bilateral
E10.3559	Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, unspecified eye
E10.3591	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye
E10.3592	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye
E10.3593	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral
E10.3599	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, unspecified eye
E10.37X1	Type 1 diabetes mellitus with diabetic macular edema, resolved following treatment, right eye
E10.37X2	Type 1 diabetes mellitus with diabetic macular edema, resolved following treatment, left eye
E10.37X3	Type 1 diabetes mellitus with diabetic macular edema, resolved following treatment, bilateral
E11.311	Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema
E11.319	Type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema
E11.3211	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye
E11.3212	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye
E11.3213	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral
E11.3219	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, unspecified eye
E11.3291	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye
E11.3292	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye
E11.3293	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral
E11.3299	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, unspecified eye

E11.3311	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye
E11.3312	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye
E11.3313	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral
E11.3319	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, unspecified eye
E11.3391	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye
E11.3392	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye
E11.3393	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral
E11.3399	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, unspecified eye
E11.3411	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye
E11.3412	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye
E11.3413	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral
E11.3419	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, unspecified eye
E11.3491	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye
E11.3492	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye
E11.3493	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral
E11.3499	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, unspecified eye
E11.3511	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye
E11.3512	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye
E11.3513	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral
E11.3519	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, unspecified eye
E11.3521	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye
E11.3522	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye
E11.3523	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral
E11.3529	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, unspecified eye
E11.3531	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye
E11.3532	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye
E11.3533	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral
E11.3539	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, unspecified eye
E11.3541	Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye
E11.3542	Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye
E11.3543	Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral
E11.3549	Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, unspecified eye
E11.3551	Type 2 diabetes mellitus with stable proliferative diabetic retinopathy, right eye
E11.3552	Type 2 diabetes mellitus with stable proliferative diabetic retinopathy, left eye
E11.3553	Type 2 diabetes mellitus with stable proliferative diabetic retinopathy, bilateral
E11.3559	Type 2 diabetes mellitus with stable proliferative diabetic retinopathy, unspecified eye
E11.3591	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye
E11.3592	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye
E11.3593	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral
E11.3599	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, unspecified eye
E11.37X1	Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, right eye
E11.37X2	Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, left eye
E11.37X3	Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, bilateral
E13.311	Other specified diabetes mellitus with unspecified diabetic retinopathy with macular edema

E13.319	Other specified diabetes mellitus with unspecified diabetic retinopathy without macular edema
E13.3211	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye
E13.3212	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye
E13.3213	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral
E13.3219	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, unspecified eye
E13.3291	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye
E13.3292	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye
E13.3293	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral
E13.3299	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, unspecified eye
E13.3311	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye
E13.3312	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye
E13.3313	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral
E13.3319	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, unspecified eye
E13.3391	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye
E13.3392	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye
E13.3393	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral
E13.3399	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, unspecified eye
E13.3411	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye
E13.3412	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye
E13.3413	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral
E13.3419	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, unspecified eye
E13.3491	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye
E13.3492	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye
E13.3493	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral
E13.3499	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, unspecified eye
E13.3511	Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye
E13.3512	Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye
E13.3513	Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral
E13.3519	Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema, unspecified eye
E13.3521	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye
E13.3522	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye
E13.3523	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral
E13.3529	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, unspecified eye
E13.3531	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye
E13.3532	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye
E13.3533	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral
E13.3539	Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, unspecified eye
E13.3541	Other specified diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye
E13.3542	Other specified diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye
E13.3543	Other specified diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral
E13.3549	Other specified diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, unspecified eye
E13.3551	Other specified diabetes mellitus with stable proliferative diabetic retinopathy, right eye
E13.3552	Other specified diabetes mellitus with stable proliferative diabetic retinopathy, left eye
E13.3553	Other specified diabetes mellitus with stable proliferative diabetic retinopathy, bilateral

E13.3559	Other specified diabetes mellitus with stable proliferative diabetic retinopathy, unspecified eye
E13.3591	Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye
E13.3592	Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye
E13.3593	Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral
E13.3599	Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema, unspecified eye
E13.37X1	Other specified diabetes mellitus with diabetic macular edema, resolved following treatment, right eye
E13.37X2	Other specified diabetes mellitus with diabetic macular edema, resolved following treatment, left eye
E13.37X3	Other specified diabetes mellitus with diabetic macular edema, resolved following treatment, bilateral
H16.143	Punctate keratitis, bilateral
H21.1X1	Other vascular disorders of iris and ciliary body, right eye
H21.1X2	Other vascular disorders of iris and ciliary body, left eye
H21.1X3	Other vascular disorders of iris and ciliary body, bilateral
H21.1X9	Other vascular disorders of iris and ciliary body, unspecified eye
H32	Chorioretinal disorders in diseases classified elsewhere
H33.001	Unspecified retinal detachment with retinal break, right eye
H33.002	Unspecified retinal detachment with retinal break, left eye
H33.003	Unspecified retinal detachment with retinal break, bilateral
H33.011	Retinal detachment with single break, right eye
H33.012	Retinal detachment with single break, left eye
H33.013	Retinal detachment with single break, bilateral
H33.021	Retinal detachment with multiple breaks, right eye
H33.022	Retinal detachment with multiple breaks, left eye
H33.023	Retinal detachment with multiple breaks, bilateral
H33.031	Retinal detachment with giant retinal tear, right eye
H33.032	Retinal detachment with giant retinal tear, left eye
H33.033	Retinal detachment with giant retinal tear, bilateral
H33.041	Retinal detachment with retinal dialysis, right eye
H33.042	Retinal detachment with retinal dialysis, left eye
H33.043	Retinal detachment with retinal dialysis, bilateral
H33.051	Total retinal detachment, right eye
H33.052	Total retinal detachment, left eye
H33.053	Total retinal detachment, bilateral
H33.101	Unspecified retinoschisis, right eye
H33.102	Unspecified retinoschisis, left eye
H33.103	Unspecified retinoschisis, bilateral
H33.111	Cyst of ora serrata, right eye
H33.112	Cyst of ora serrata, left eye
H33.113	Cyst of ora serrata, bilateral
H33.121	Parasitic cyst of retina, right eye
H33.122	Parasitic cyst of retina, left eye
H33.123	Parasitic cyst of retina, bilateral
H33.191	Other retinoschisis and retinal cysts, right eye
H33.192	Other retinoschisis and retinal cysts, left eye
H33.193	Other retinoschisis and retinal cysts, bilateral

H33.21	Serous retinal detachment, right eye
H33.22	Serous retinal detachment, left eye
H33.23	Serous retinal detachment, bilateral
H33.301	Unspecified retinal break, right eye
H33.302	Unspecified retinal break, left eye
H33.303	Unspecified retinal break, bilateral
H33.311	Horseshoe tear of retina without detachment, right eye
H33.312	Horseshoe tear of retina without detachment, left eye
H33.313	Horseshoe tear of retina without detachment, bilateral
H33.321	Round hole, right eye
H33.322	Round hole, left eye
H33.323	Round hole, bilateral
H33.331	Multiple defects of retina without detachment, right eye
H33.332	Multiple defects of retina without detachment, left eye
H33.333	Multiple defects of retina without detachment, bilateral
H33.41	Traction detachment of retina, right eye
H33.42	Traction detachment of retina, left eye
H33.43	Traction detachment of retina, bilateral
H33.8	Other retinal detachments
H34.00	Transient retinal artery occlusion, unspecified eye
H34.01	Transient retinal artery occlusion, right eye
H34.02	Transient retinal artery occlusion, left eye
H34.03	Transient retinal artery occlusion, bilateral
H34.10	Central retinal artery occlusion, unspecified eye
H34.11	Central retinal artery occlusion, right eye
H34.12	Central retinal artery occlusion, left eye
H34.13	Central retinal artery occlusion, bilateral
H34.211	Partial retinal artery occlusion, right eye
H34.212	Partial retinal artery occlusion, left eye
H34.213	Partial retinal artery occlusion, bilateral
H34.219	Partial retinal artery occlusion, unspecified eye
H34.231	Retinal artery branch occlusion, right eye
H34.232	Retinal artery branch occlusion, left eye
H34.233	Retinal artery branch occlusion, bilateral
H34.239	Retinal artery branch occlusion, unspecified eye
H34.8110	Central retinal vein occlusion, right eye, with macular edema
H34.8111	Central retinal vein occlusion, right eye, with retinal neovascularization
H34.8112	Central retinal vein occlusion, right eye, stable
H34.8120	Central retinal vein occlusion, left eye, with macular edema
H34.8121	Central retinal vein occlusion, left eye, with retinal neovascularization
H34.8122	Central retinal vein occlusion, left eye, stable
H34.8130	Central retinal vein occlusion, bilateral, with macular edema
H34.8131	Central retinal vein occlusion, bilateral, with retinal neovascularization
H34.8132	Central retinal vein occlusion, bilateral, stable

H34.8190	Central retinal vein occlusion, unspecified eye, with macular edema
H34.8191	Central retinal vein occlusion, unspecified eye, with retinal neovascularization
H34.8192	Central retinal vein occlusion, unspecified eye, stable
H34.821	Venous engorgement, right eye
H34.822	Venous engorgement, left eye
H34.823	Venous engorgement, bilateral
H34.829	Venous engorgement, unspecified eye
H34.8310	Tributary (branch) retinal vein occlusion, right eye, with macular edema
H34.8311	Tributary (branch) retinal vein occlusion, right eye, with retinal neovascularization
H34.8312	Tributary (branch) retinal vein occlusion, right eye, stable
H34.8320	Tributary (branch) retinal vein occlusion, left eye, with macular edema
H34.8321	Tributary (branch) retinal vein occlusion, left eye, with retinal neovascularization
H34.8322	Tributary (branch) retinal vein occlusion, left eye, stable
H34.8330	Tributary (branch) retinal vein occlusion, bilateral, with macular edema
H34.8331	Tributary (branch) retinal vein occlusion, bilateral, with retinal neovascularization
H34.8332	Tributary (branch) retinal vein occlusion, bilateral, stable
H34.8390	Tributary (branch) retinal vein occlusion, unspecified eye, with macular edema
H34.8391	Tributary (branch) retinal vein occlusion, unspecified eye, with retinal neovascularization
H34.8392	Tributary (branch) retinal vein occlusion, unspecified eye, stable
H34.9	Unspecified retinal vascular occlusion
H35.00	Unspecified background retinopathy
H35.011	Changes in retinal vascular appearance, right eye
H35.012	Changes in retinal vascular appearance, left eye
H35.013	Changes in retinal vascular appearance, bilateral
H35.019	Changes in retinal vascular appearance, unspecified eye
H35.021	Exudative retinopathy, right eye
H35.022	Exudative retinopathy, left eye
H35.023	Exudative retinopathy, bilateral
H35.029	Exudative retinopathy, unspecified eye
H35.031	Hypertensive retinopathy, right eye
H35.032	Hypertensive retinopathy, left eye
H35.033	Hypertensive retinopathy, bilateral
H35.039	Hypertensive retinopathy, unspecified eye
H35.041	Retinal micro-aneurysms, unspecified, right eye
H35.042	Retinal micro-aneurysms, unspecified, left eye
H35.043	Retinal micro-aneurysms, unspecified, bilateral
H35.049	Retinal micro-aneurysms, unspecified, unspecified eye
H35.051	Retinal neovascularization, unspecified, right eye
H35.052	Retinal neovascularization, unspecified, left eye
H35.053	Retinal neovascularization, unspecified, bilateral
H35.059	Retinal neovascularization, unspecified, unspecified eye
H35.061	Retinal vasculitis, right eye
H35.062	Retinal vasculitis, left eye
H35.063	Retinal vasculitis, bilateral

H35.069	Retinal vasculitis, unspecified eye
H35.071	Retinal telangiectasis, right eye
H35.072	Retinal telangiectasis, left eye
H35.073	Retinal telangiectasis, bilateral
H35.079	Retinal telangiectasis, unspecified eye
H35.09	Other intraretinal microvascular abnormalities
H35.141	Retinopathy of prematurity, stage 3, right eye
H35.142	Retinopathy of prematurity, stage 3, left eye
H35.143	Retinopathy of prematurity, stage 3, bilateral
H35.149	Retinopathy of prematurity, stage 3, unspecified eye
H35.151	Retinopathy of prematurity, stage 4, right eye
H35.152	Retinopathy of prematurity, stage 4, left eye
H35.153	Retinopathy of prematurity, stage 4, bilateral
H35.159	Retinopathy of prematurity, stage 4, unspecified eye
H35.161	Retinopathy of prematurity, stage 5, right eye
H35.162	Retinopathy of prematurity, stage 5, left eye
H35.163	Retinopathy of prematurity, stage 5, bilateral
H35.169	Retinopathy of prematurity, stage 5, unspecified eye
H35.20	Other non-diabetic proliferative retinopathy, unspecified eye
H35.21	Other non-diabetic proliferative retinopathy, right eye
H35.22	Other non-diabetic proliferative retinopathy, left eye
H35.23	Other non-diabetic proliferative retinopathy, bilateral
H35.3131	Nonexudative age-related macular degeneration, bilateral, early dry stage
H35.3210	Exudative age-related macular degeneration, right eye, stage unspecified
H35.3211	Exudative age-related macular degeneration, right eye, with active choroidal neovascularization
H35.3212	Exudative age-related macular degeneration, right eye, with inactive choroidal neovascularization
H35.3213	Exudative age-related macular degeneration, right eye, with inactive scar
H35.3220	Exudative age-related macular degeneration, left eye, stage unspecified
H35.3221	Exudative age-related macular degeneration, left eye, with active choroidal neovascularization
H35.3222	Exudative age-related macular degeneration, left eye, with inactive choroidal neovascularization
H35.3223	Exudative age-related macular degeneration, left eye, with inactive scar
H35.3230	Exudative age-related macular degeneration, bilateral, stage unspecified
H35.3231	Exudative age-related macular degeneration, bilateral, with active choroidal neovascularization
H35.3232	Exudative age-related macular degeneration, bilateral, with inactive choroidal neovascularization
H35.3233	Exudative age-related macular degeneration, bilateral, with inactive scar
H35.3290	Exudative age-related macular degeneration, unspecified eye, stage unspecified
H35.3291	Exudative age-related macular degeneration, unspecified eye, with active choroidal neovascularization
H35.3292	Exudative age-related macular degeneration, unspecified eye, with inactive choroidal neovascularization
H35.3293	Exudative age-related macular degeneration, unspecified eye, with inactive scar
H35.33	Angioid streaks of macula
H35.341	Macular cyst, hole, or pseudohole, right eye
H35.342	Macular cyst, hole, or pseudohole, left eye
H35.343	Macular cyst, hole, or pseudohole, bilateral
H35.351	Cystoid macular degeneration, right eye

H35.352	Cystoid macular degeneration, left eye
H35.353	Cystoid macular degeneration, bilateral
H35.359	Cystoid macular degeneration, unspecified eye
H35.373	Puckering of macula, bilateral
H35.81	Retinal edema
H35.82	Retinal ischemia
H36.811	Nonproliferative sickle-cell retinopathy, right eye
H36.812	Nonproliferative sickle-cell retinopathy, left eye
H36.813	Nonproliferative sickle-cell retinopathy, bilateral
H36.819	Nonproliferative sickle-cell retinopathy, unspecified eye
H36.821	Proliferative sickle-cell retinopathy, right eye
H36.822	Proliferative sickle-cell retinopathy, left eye
H36.823	Proliferative sickle-cell retinopathy, bilateral
H36.829	Proliferative sickle-cell retinopathy, unspecified eye
H36.89	Other retinal disorders in diseases classified elsewhere
H40.50X0	Glaucoma secondary to other eye disorders, unspecified eye, stage unspecified
H40.50X1	Glaucoma secondary to other eye disorders, unspecified eye, mild stage
H40.50X2	Glaucoma secondary to other eye disorders, unspecified eye, moderate stage
H40.50X3	Glaucoma secondary to other eye disorders, unspecified eye, severe stage
H40.50X4	Glaucoma secondary to other eye disorders, unspecified eye, indeterminate stage
H40.51X0	Glaucoma secondary to other eye disorders, right eye, stage unspecified
H40.51X1	Glaucoma secondary to other eye disorders, right eye, mild stage
H40.51X2	Glaucoma secondary to other eye disorders, right eye, moderate stage
H40.51X3	Glaucoma secondary to other eye disorders, right eye, severe stage
H40.51X4	Glaucoma secondary to other eye disorders, right eye, indeterminate stage
H40.52X0	Glaucoma secondary to other eye disorders, left eye, stage unspecified
H40.52X1	Glaucoma secondary to other eye disorders, left eye, mild stage
H40.52X2	Glaucoma secondary to other eye disorders, left eye, moderate stage
H40.52X3	Glaucoma secondary to other eye disorders, left eye, severe stage
H40.52X4	Glaucoma secondary to other eye disorders, left eye, indeterminate stage
H40.53X0	Glaucoma secondary to other eye disorders, bilateral, stage unspecified
H40.53X1	Glaucoma secondary to other eye disorders, bilateral, mild stage
H40.53X2	Glaucoma secondary to other eye disorders, bilateral, moderate stage
H40.53X3	Glaucoma secondary to other eye disorders, bilateral, severe stage
H40.53X4	Glaucoma secondary to other eye disorders, bilateral, indeterminate stage
H44.20	Degenerative myopia, unspecified eye
H44.21	Degenerative myopia, right eye
H44.22	Degenerative myopia, left eye
H44.23	Degenerative myopia, bilateral
H44.2A1	Degenerative myopia with choroidal neovascularization, right eye
H44.2A2	Degenerative myopia with choroidal neovascularization, left eye
H44.2A3	Degenerative myopia with choroidal neovascularization, bilateral
H44.2A9	Degenerative myopia with choroidal neovascularization, unspecified eye
H44.2B1	Degenerative myopia with macular hole, right eye

H44.2B2	Degenerative myopia with macular hole, left eye
H44.2B3	Degenerative myopia with macular hole, bilateral
H44.2B9	Degenerative myopia with macular hole, unspecified eye
H44.2C1	Degenerative myopia with retinal detachment, right eye
H44.2C2	Degenerative myopia with retinal detachment, left eye
H44.2C3	Degenerative myopia with retinal detachment, bilateral
H44.2D1	Degenerative myopia with foveoschisis, right eye
H44.2D2	Degenerative myopia with foveoschisis, left eye
H44.2D3	Degenerative myopia with foveoschisis, bilateral
H44.2D9	Degenerative myopia with foveoschisis, unspecified eye
H44.2E1	Degenerative myopia with other maculopathy, right eye
H44.2E2	Degenerative myopia with other maculopathy, left eye
H44.2E3	Degenerative myopia with other maculopathy, bilateral
H44.2E9	Degenerative myopia with other maculopathy, unspecified eye

Insulin Dependent and Gestational Diabetes Codes	**Descriptions**
E10.10	Type 1 diabetes mellitus with ketoacidosis without coma
E10.11	Type 1 diabetes mellitus with ketoacidosis with coma
E10.21	Type 1 diabetes mellitus with diabetic nephropathy
E10.22	Type 1 diabetes mellitus with diabetic chronic kidney disease
E10.29	Type 1 diabetes mellitus with other diabetic kidney complication
E10.311	Type 1 diabetes mellitus with unspecified diabetic retinopathy with macular edema
E10.319	Type 1 diabetes mellitus with unspecified diabetic retinopathy without macular edema
E10.3211	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye
E10.3212	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye
E10.3213	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral
E10.3219	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, unspecified eye
E10.3291	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye
E10.3292	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye
E10.3293	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral
E10.3299	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, unspecified eye
E10.3311	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye
E10.3312	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye
E10.3313	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral
E10.3319	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, unspecified eye
E103391	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye
E10.3392	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye
E10.3393	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral
E10.3399	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, unspecified eye
E10.3411	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye
E10.3412	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye
E10.3413	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral

E10.3419	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, unspecified eye
E10.3491	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye
E10.3492	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye
E10.3493	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral
E10.3499	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, unspecified eye
E10.3511	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye
E10.3512	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye
E10.3513	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral
E10.3519	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema, unspecified eye
E10.3521	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye
E10.3522	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye
E10.3523	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral
E10.3529	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, unspecified eye
E10.3531	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye
E10.3532	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye
E10.3533	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral
E10.3539	Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, unspecified eye
E10.3541	Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye
E10.3542	Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye
E10.3543	Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral
E10.3549	Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, unspecified eye
E10.3551	Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, right eye
E10.3552	Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, left eye
E10.3553	Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, bilateral
E10.3559	Type 1 diabetes mellitus with stable proliferative diabetic retinopathy, unspecified eye
E10.3591	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye
E10.3592	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye
E10.3593	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral
E10.3599	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema, unspecified eye
E10.36	Type 1 diabetes mellitus with diabetic cataract
E10.37X1	Type 1 diabetes mellitus with diabetic macular edema, resolved following treatment, right eye
E10.37X2	Type 1 diabetes mellitus with diabetic macular edema, resolved following treatment, left eye
E10.37X3	Type 1 diabetes mellitus with diabetic macular edema, resolved following treatment, bilateral
E10.37X9	Type 1 diabetes mellitus with diabetic macular edema, resolved following treatment, unspecified eye
E10.39	Type 1 diabetes mellitus with other diabetic ophthalmic complication
E10.40	Type 1 diabetes mellitus with diabetic neuropathy, unspecified
E10.41	Type 1 diabetes mellitus with diabetic mononeuropathy
E10.42	Type 1 diabetes mellitus with diabetic polyneuropathy
E10.43	Type 1 diabetes mellitus with diabetic autonomic (poly)neuropathy
E10.44	Type 1 diabetes mellitus with diabetic amyotrophy
E10.49	Type 1 diabetes mellitus with other diabetic neurological complication
E10.51	Type 1 diabetes mellitus with diabetic peripheral angiopathy without gangrene
E10.52	Type 1 diabetes mellitus with diabetic peripheral angiopathy with gangrene
E10.59	Type 1 diabetes mellitus with other circulatory complications

E10.610	Type 1 diabetes mellitus with diabetic neuropathic arthropathy
E10.618	Type 1 diabetes mellitus with other diabetic arthropathy
E10.620	Type 1 diabetes mellitus with diabetic dermatitis
E10.621	Type 1 diabetes mellitus with foot ulcer
E10.622	Type 1 diabetes mellitus with other skin ulcer
E10.628	Type 1 diabetes mellitus with other skin complications
E10.630	Type 1 diabetes mellitus with periodontal disease
E10.638	Type 1 diabetes mellitus with other oral complications
E10.641	Type 1 diabetes mellitus with hypoglycemia with coma
E10.649	Type 1 diabetes mellitus with hypoglycemia without coma
E10.65	Type 1 diabetes mellitus with hyperglycemia
E10.69	Type 1 diabetes mellitus with other specified complication
E10.8	Type 1 diabetes mellitus with unspecified complications
E10.9	Type 1 diabetes mellitus without complications
E10.A0	Type 1 diabetes mellitus, presymptomatic, unspecified
E10.A1	Type 1 diabetes mellitus, presymptomatic, Stage 1
E10.A2	Type 1 diabetes mellitus, presymptomatic, Stage 2
E11.00	Type 2 diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
E11.01	Type 2 diabetes mellitus with hyperosmolarity with coma
E11.21	Type 2 diabetes mellitus with diabetic nephropathy
E11.22	Type 2 diabetes mellitus with diabetic chronic kidney disease
E11.29	Type 2 diabetes mellitus with other diabetic kidney complication
E11.311	Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema
E11.319	Type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema
E11.3211	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, right eye
E11.3212	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, left eye
E11.3213	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, bilateral
E11.3219	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema, unspecified eye
E11.3291	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, right eye
E11.3292	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, left eye
E11.3293	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, bilateral
E11.3299	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema, unspecified eye
E11.3311	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, right eye
E11.3312	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, left eye
E11.3313	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, bilateral
E11.3319	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema, unspecified eye
E11.3391	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, right eye
E11.3392	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, left eye
E11.3393	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, bilateral
E11.3399	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema, unspecified eye
E11.3411	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, right eye
E11.3412	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, left eye
E11.3413	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, bilateral
E11.3419	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, unspecified eye

E11.3491	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, right eye
E11.3492	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, left eye
E11.3493	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, bilateral
E11.3499	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema, unspecified eye
E11.3511	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, right eye
E11.3512	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, left eye
E11.3513	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, bilateral
E11.3519	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, unspecified eye
E11.3521	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, right eye
E11.3522	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, left eye
E11.3523	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, bilateral
E11.3529	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula, unspecified eye
E11.3531	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, right eye
E11.3532	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, left eye
E11.3533	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, bilateral
E11.3539	Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula, unspecified eye
E11.3541	Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, right eye
E11.3542	Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, left eye
E11.3543	Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, bilateral
E11.3549	Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment, unspecified eye
E11.3551	Type 2 diabetes mellitus with stable proliferative diabetic retinopathy, right eye
E11.3552	Type 2 diabetes mellitus with stable proliferative diabetic retinopathy, left eye
E11.3553	Type 2 diabetes mellitus with stable proliferative diabetic retinopathy, bilateral
E11.3559	Type 2 diabetes mellitus with stable proliferative diabetic retinopathy, unspecified eye
E11.3591	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, right eye
E11.3592	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, left eye
E11.3593	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral
E11.3599	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema, unspecified eye
E11.36	Type 2 diabetes mellitus with diabetic cataract
E11.37X1	Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, right eye
E11.37X2	Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, left eye
E11.37X3	Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, bilateral
E11.37X9	Type 2 diabetes mellitus with diabetic macular edema, resolved following treatment, unspecified eye
E11.39	Type 2 diabetes mellitus with other diabetic ophthalmic complication
E11.40	Type 2 diabetes mellitus with diabetic neuropathy, unspecified
E11.41	Type 2 diabetes mellitus with diabetic mononeuropathy
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy
E11.43	Type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy
E11.44	Type 2 diabetes mellitus with diabetic amyotrophy
E11.49	Type 2 diabetes mellitus with other diabetic neurological complication
E11.610	Type 2 diabetes mellitus with diabetic neuropathic arthropathy
E11.618	Type 2 diabetes mellitus with other diabetic arthropathy
E11.620	Type 2 diabetes mellitus with diabetic dermatitis
E11.621	Type 2 diabetes mellitus with foot ulcer

E11.622	Type 2 diabetes mellitus with other skin ulcer
E11.628	Type 2 diabetes mellitus with other skin complications
E11.630	Type 2 diabetes mellitus with periodontal disease
E11.638	Type 2 diabetes mellitus with other oral complications
E11.641	Type 2 diabetes mellitus with hypoglycemia with coma
E11.649	Type 2 diabetes mellitus with hypoglycemia without coma
E11.65	Type 2 diabetes mellitus with hyperglycemia
E11.69	Type 2 diabetes mellitus with other specified complication
O24.011	Pre-existing type 1 diabetes mellitus, in pregnancy, first trimester
O24.012	Pre-existing type 1 diabetes mellitus, in pregnancy, second trimester
O24.013	Pre-existing type 1 diabetes mellitus, in pregnancy, third trimester
O24.019	Pre-existing type 1 diabetes mellitus, in pregnancy, unspecified trimester
O24.02	Pre-existing type 1 diabetes mellitus, in childbirth
O24.03	Pre-existing type 1 diabetes mellitus, in the puerperium
O24.111	Pre-existing type 2 diabetes mellitus, in pregnancy, first trimester
O24.112	Pre-existing type 2 diabetes mellitus, in pregnancy, second trimester
O24.113	Pre-existing type 2 diabetes mellitus, in pregnancy, third trimester
O24.119	Pre-existing type 2 diabetes mellitus, in pregnancy, unspecified trimester
O24.12	Pre-existing type 2 diabetes mellitus, in childbirth
O24.13	Pre-existing type 2 diabetes mellitus, in the puerperium
O24.311	Unspecified pre-existing diabetes mellitus in pregnancy, first trimester
O24.312	Unspecified pre-existing diabetes mellitus in pregnancy, second trimester
O24.313	Unspecified pre-existing diabetes mellitus in pregnancy, third trimester
O24.319	Unspecified pre-existing diabetes mellitus in pregnancy, unspecified trimester
O24.32	Unspecified pre-existing diabetes mellitus in childbirth
O24.33	Unspecified pre-existing diabetes mellitus in the puerperium
O24.410	Gestational diabetes mellitus in pregnancy, diet controlled
O24.414	Gestational diabetes mellitus in pregnancy, insulin controlled
O24.415	Gestational diabetes mellitus in pregnancy, controlled by oral hypoglycemic drugs
O24.419	Gestational diabetes mellitus in pregnancy, unspecified control
O24.420	Gestational diabetes mellitus in childbirth, diet controlled
O24.424	Gestational diabetes mellitus in childbirth, insulin controlled
O24.425	Gestational diabetes mellitus in childbirth, controlled by oral hypoglycemic drugs
O24.429	Gestational diabetes mellitus in childbirth, unspecified control
O24.430	Gestational diabetes mellitus in the puerperium, diet controlled
O24.434	Gestational diabetes mellitus in the puerperium, insulin controlled
O24.435	Gestational diabetes mellitus in puerperium, controlled by oral hypoglycemic drugs
O24.439	Gestational diabetes mellitus in the puerperium, unspecified control
O24.811	Other pre-existing diabetes mellitus in pregnancy, first trimester
O24.812	Other pre-existing diabetes mellitus in pregnancy, second trimester
O24.813	Other pre-existing diabetes mellitus in pregnancy, third trimester
O24.819	Other pre-existing diabetes mellitus in pregnancy, unspecified trimester
O24.82	Other pre-existing diabetes mellitus in childbirth
O24.83	Other pre-existing diabetes mellitus in the puerperium

O24.911	Unspecified diabetes mellitus in pregnancy, first trimester
O24.912	Unspecified diabetes mellitus in pregnancy, second trimester
O24.913	Unspecified diabetes mellitus in pregnancy, third trimester
O24.919	Unspecified diabetes mellitus in pregnancy, unspecified trimester
O24.92	Unspecified diabetes mellitus in childbirth
O24.93	Unspecified diabetes mellitus in the puerperium
Z79.4	Long term (current) use of insulin

2025 MHI Code Matrix Updates

Q3 2025 Updates						
REQ#	RECEIVED	EFFECTIVE	SERVICE CATEGORY	UPDATE TYPE	CODES	NOTES
2685	1/17/2025	7/1/2025	Hyperbaric and Wound Care	Add (PA)	15271,15275,15273,15274,15277,15278,15272,15276,Q4238,Q4180,A2005,Q4164,Q4194,Q4204,Q4151	
2735	3/10/2025	4/1/2025	Transplants/Gene Therapy	Add (PA)	C9301	**Code will be replaced by permantent code Q2058 effective 7/1/25. Note: will be in Evolent PA scope for Evolent partnered plans Medicare: IL Medicaid: FL, IL, KY, MS, NV, SC Marketplace: FL, MS, SC, WA, WI
2736	3/10/2025	7/1/2025	Durable Medical Equipment (DME)	Add (PA)	L7406,L6700,L0720,L5827	
2739	3/13/2025	4/1/2025	Healthcare Administered Drugs	Add (PA)	C9302, C9303	New Pharmacy Codes for 4/1/2025. Drugs are in EVOLENT SCOPE. Medicare: IL Medicaid: FL, IL, KY, MS, NV, SC, WA Marketplace: FL, MS, SC, WA, WI
2740	3/13/2025	4/1/2025	Healthcare Administered Drugs	Add (PA)	C9304	
2749	3/27/2025	4/1/2025	Healthcare Administered Drugs	PA Update	Q5148	Add to Evolent scope for oncology partnered plans. Already requires PA effective 4/1/25 Medicare: IL Medicaid: FL, IL, KY, MS, NV, SC Marketplace: FL, MS, SC, WA, WI
2755	4/7/2025	7/1/2025	Transplants/Gene Therapy	Add (PA)	J3391	New Code for Lenmeldy (gene therapy)
2759	4/7/2025	7/1/2025	Healthcare Administered Drugs	Add (PA)	Q2058, J1326, J9276	Replacement codes effective 7/1/2025; C Codes were all added to Evolent Scope Q2-2025, 3/28/2025 Notice; Q2058 replaces C9301; NC in WA J1326 replaces C9303 Onco PA all J9276 replaces C9302 Onco PA all Updates applicable only where PA for C codes was applicable.
2760	4/7/2025	7/1/2025	Healthcare Administered Drugs	Add (PA)	Q5153, J7356, Q5098, Q5100, Q5099	
2761	4/7/2025	7/1/2025	Healthcare Administered Drugs	Add (PA)	J9341, J9174, J9342	Medicare: PA required for IL all ages Marketplace: PA required for all ages: FL, MS, SC, WA, WI Medicaid: PA required for adults ONLY: FL, IL, KY, MS, NV, SC, WA
2762	4/7/2025	7/1/2025	Healthcare Administered Drugs	Add (PA)	J9382, J9275, J9289	New Oncology Codes for 7/1/2025. Evolent Scope Review needed. Exception Requests will be entered for MI MCD and NM MCD/Marketplace.
2763	4/7/2025	7/1/2025	Healthcare Administered Drugs	Add (PA)	J7172	Replacement Code for Hympavzi (C9304); Only applicable where not carved out Florida Carve Out: [This service is carved out to FFS.] UT Medicaid (NOT CHIP) Carve out: [Eligible for CHIP Coverage Only. Carved out to state FFS for Medicaid.]
2764	4/7/2025	7/1/2025	Healthcare Administered Drugs	Deleted/Invalid Codes	C9301, C9302, C9303, C9304, J9340	
2774	4/18/2025	10/1/2025	OP Hosp/Amb Surgery Center (ASC) procedures	Remove (PA)	33904	Add on code for pulmonary artery stent placement. Was put on PA due to Evolent, however Evolent no longer PA's due to add-on nature.
2788	4/30/2025	7/1/2025	Behavioral/Mental Health, Alcohol-Chemical Dependency	Add (PA)	H0035, H2012, T2023, H2015, H0040 PA after 16 units per calendar year: H0015, S9480 PA after 48 units combined per calendar year: ABA therapy (cumulative of 97153, 97154, 97155, 97156, 97157, 97158)	COVID PA hold lifted PA requirements for H0038 and H2027 pending confirmation

Medicaid Prior Auth (PA) Code Matrix **Effective Q3, 2025**

THIS MATRIX IS NOT TO BE UTILIZED TO MAKE BENEFIT COVERAGE DETERMINATIONS.

We attempt to provide the most current and accurate information on this PA Matrix. Obtaining authorization does not guarantee payment. The plan retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of the service, correct coding, billing practices and whether the service was provided in the most appropriate and cost-effective setting of care. If there is a question that Prior Authorization is needed, please refer to your Provider Manual or submit a PA Request Form.

This Matrix is for Outpatient services.

All Elective Inpatient Admissions to Acute Hospitals, Skilled Nursing Facilities (SNF), Rehabilitation Facilities (ARF), or Long Term Acute Care Hospitals (LTACH) require Prior Authorization except as excluded by law.

No PA is required for office visits at Participating (PAR) Network Providers.

All NON-PAR Providers require authorization regardless of services provided or codes submitted, except for Emergency Services, as delineated in the Prior Authorization guides, or as required by law. Molina Clinical Services completes Utilization Management for certain Healthcare Administered Drugs. For any drugs on the prior authorization list that use a temporary C code or other temporary HCPCS code that is not unique to a specific drug, which are later assigned a new HCPCS code, will still require prior authorization for such drug even after it has been assigned a new HCPCS code, until otherwise noted in the Prior Authorization list.

Code	Description	Service Category	MHI PA Required?	Evolent PA Required?	MHI Code Notes	Evolent KY 1/1/21 Cardiology Adult 18+	Evolent KY 10/1/22 Oncology Adult 18+
80307	DRUG TEST PRSMV INSTRMNT CHEM ANALYZERS PR DATE	Behavioral/Mental Health, Alcohol-Chemical Dependency	Y		Presumptive urine drug testing is limited to 35 tests per calendar year (includes any combination of 80305, 80306, 80307).		
90867	THRPTC RPTTV TMS TX INTL W MAP MOTR THRESHLD DLVRY AND MNGMNT	Behavioral/Mental Health, Alcohol-Chemical Dependency	N		See Ky Exceptions : No PA		
90868	THERAP REPETITIVE TMS TX SUBSEQ DELIVERY AND MNG	Behavioral/Mental Health, Alcohol-Chemical Dependency	N		See Ky Exceptions : No PA		
90869	REPET TMS TX SUBSEQ MOTR THRESHLD W DLVRY AND MNGMNT	Behavioral/Mental Health, Alcohol-Chemical Dependency	N		See Ky Exceptions : No PA		
90870	ELECTROCONVULSIVE THERAPY (ECT)	Behavioral/Mental Health, Alcohol-Chemical Dependency	N		See Ky Exceptions : No PA		
97153	ADAPTIVE BEHAVIOR TX BY PROTOCOL TECH EA 15 MIN	Behavioral/Mental Health, Alcohol-Chemical Dependency	Y		Prior authorization required after 48 units, for any combination of CPT Codes: 97153, 97154, 97155, 97156, 97157,97158 per member per calendar year. **Limited to Autism Diagnosis**		
97154	GROUP ADAPTIVE BHV TX BY PROTOCOL TECH EA 15 MIN	Behavioral/Mental Health, Alcohol-Chemical Dependency	Y		Prior authorization required after 48 units, for any combination of CPT Codes: 97153, 97154, 97155, 97156, 97157,97158 per member per calendar year. **Limited to Autism Diagnosis**		
97155	ADAPT BHV TX PRTCL MODIFICAJ PHYS QHP EA 15 MIN	Behavioral/Mental Health, Alcohol-Chemical Dependency	Y		Prior authorization required after 48 units, for any combination of CPT Codes: 97153, 97154, 97155, 97156, 97157,97158 per member per calendar year. **Limited to Autism Diagnosis**		
97156	FAMILY ADAPT BHV TX GDN PHYS QHP EA 15 MIN	Behavioral/Mental Health, Alcohol-Chemical Dependency	Y		Prior authorization required after 48 units, for any combination of CPT Codes: 97153, 97154, 97155, 97156, 97157,97158 per member per calendar year. **Limited to Autism Diagnosis**		
97157	MULTIPLE FAM GROUP BHV TX GDN PHYS QHP EA 15 MIN	Behavioral/Mental Health, Alcohol-Chemical Dependency	Y		Prior authorization required after 48 units, for any combination of CPT Codes: 97153, 97154, 97155, 97156, 97157,97158 per member per calendar year. **Limited to Autism Diagnosis**		
97158	GRP ADAPT BHV PRTCL MODIFICAN PHYS QHP EA 15 MIN	Behavioral/Mental Health, Alcohol-Chemical Dependency	Y		Prior authorization required after 48 units, for any combination of CPT Codes: 97153, 97154, 97155, 97156, 97157,97158 per member per calendar year. **Limited to Autism Diagnosis**		
0373T	ADAPT BHV TX PRTCL MODIFICAJ EA 15 MIN TECH TIME	Behavioral/Mental Health, Alcohol-Chemical Dependency	N		See Ky Exceptions		
G0480	DRUG TEST DEF 1-7 DRUG CLASSES	Behavioral/Mental Health, Alcohol-Chemical Dependency	Y		Definitive urine drug testing is limited to 16 tests per calendar year (includes any combination of G0408, G0481, G0482, G0483, G0659).		
G0481	DRUG TEST DEF 8-14 DRUG CLASSES	Behavioral/Mental Health, Alcohol-Chemical Dependency	Y		Definitive urine drug testing is limited to 16 tests per calendar year (includes any combination of G0408, G0481, G0482, G0483, G0659).		
G0482	DRUG TEST DEF 15-21 DRUG CLASSES	Behavioral/Mental Health, Alcohol-Chemical Dependency	Y		Definitive urine drug testing is limited to 16 tests per calendar year (includes any combination of G0408, G0481, G0482, G0483, G0659).		
G0483	DRUG TEST DEF 22 OR MORE DRUG CLASSES	Behavioral/Mental Health, Alcohol-Chemical Dependency	Y		Definitive urine drug testing is limited to 16 tests per calendar year (includes any combination of G0408, G0481, G0482, G0483, G0659).		
G0659	DRUG TEST DEF SIMPLE ALL CL	Behavioral/Mental Health, Alcohol-Chemical Dependency	Y		Definitive urine drug testing is limited to 16 tests per calendar year (includes any combination of G0408, G0481, G0482, G0483, G0659).		
H0008	ALCOHOL AND OR DRUG SRVC; SUB-ACUTE DTOX HOSP IP	Behavioral/Mental Health, Alcohol-Chemical Dependency	N		See Ky Exceptions		
H0009	ALCOHOL AND OR DRUG SERVICES; ACUTE DTOX HOSP IP	Behavioral/Mental Health, Alcohol-Chemical Dependency	N		See Ky Exceptions		
H0010	ALCOHOL AND / DRUG SRVC; SUB-ACUTE DTOX RES PROG IP	Behavioral/Mental Health, Alcohol-Chemical Dependency	N		See Ky Exceptions		
H0011	ALCOHOL AND / DRUG SERVICES; ACUTE DTOX RES PROG IP	Behavioral/Mental Health, Alcohol-Chemical Dependency	Y				
H0012	ALCOHOL AND DRUG SRVC; SUB-ACUTE DTOX RES PROG OP	Behavioral/Mental Health, Alcohol-Chemical Dependency	N		See Ky Exceptions		
H0013	ALCOHOL AND DRUG SERVICES; ACUTE DTOX RES PROG OP	Behavioral/Mental Health, Alcohol-Chemical Dependency	N		See Ky Exceptions		
H0014	ALCOHOL AND OR DRUG SERVICES; AMB DETOXIFICATION	Behavioral/Mental Health, Alcohol-Chemical Dependency	N		See Ky Exceptions		
H0015	ALCOHOL AND/OR DRUG SRVCS	Behavioral/Mental Health, Alcohol-Chemical Dependency	Y		No PA required for first 16 units.		
H0016	ALCOHOL AND OR DRUG SERVICES; MEDICAL SOMATIC	Behavioral/Mental Health, Alcohol-Chemical Dependency	N		See Ky Exceptions		
H0017	BEHAVIORAL HEALTH; RES W O ROOM AND BOARD PER DIEM	Behavioral/Mental Health, Alcohol-Chemical Dependency	N		See Ky Exceptions		
H0018	BHVAL HEALTH; SHORT-TERM RES W O ROOM AND BOARD-DIEM	Behavioral/Mental Health, Alcohol-Chemical Dependency	N		See Ky Exceptions		
H0019	BHVAL HEALTH; LONG-TERM RES W/O ROOM AND BOARD-DIEM	Behavioral/Mental Health, Alcohol-Chemical Dependency	N		See Ky Exceptions		
H0035	MENTAL HEALTH PARTIAL HOSP TX UNDER 24 HOURS	Behavioral/Mental Health, Alcohol-Chemical Dependency	Y		Six (6) auth free dates of service per Calander year		
H0038	PEER SUPPORT SERVICES (INDIVIDUAL AND GROUP H0038 HQ)	Behavioral/Mental Health, Alcohol-Chemical Dependency	Y		No prior authorization required for first 200 units per member per calendar year (includes H0038 and H0038 HQ Group cummulative)		
H0040	ASSERT COMM TX PROG - PER DIEM	Behavioral/Mental Health, Alcohol-Chemical Dependency	Y				
H0046	MENTAL HEALTH SERVICES NOT OTHERWISE SPECIFIED	Behavioral/Mental Health, Alcohol-Chemical Dependency	N		See Ky Exceptions		
H2012	BEHAVIORAL HEALTH DAY TREATMENT PER HOUR	Behavioral/Mental Health, Alcohol-Chemical Dependency	Y		Six (6) auth free dates of service. Auth required after six.		
H2013	PSYCHIATRIC HEALTH FACILITY SERVICE PER DIEM	Behavioral/Mental Health, Alcohol-Chemical Dependency	N		See Ky Exceptions		
H2014	ALCOHOL AND OR DRUG SERVICES; AMB DETOXIFICATION	Behavioral/Mental Health, Alcohol-Chemical Dependency	N		See Ky Exceptions		
H2015	Comprehensive Community Supports	Behavioral/Mental Health, Alcohol-Chemical Dependency	Y				
H2016	COMP COMMUNITY SUPPORT SERVICES PER DIEM	Behavioral/Mental Health, Alcohol-Chemical Dependency	N		See Ky Exceptions		
H2018	PSYCHOSOCIAL REHABILITATION SERVICES PER DIEM	Behavioral/Mental Health, Alcohol-Chemical Dependency	N		See Ky Exceptions		
H2019	Therapeutic Rehabilitation Program	Behavioral/Mental Health, Alcohol-Chemical Dependency	Y				
H2020	THERAPEUTIC BEHAVIORAL SERVICES PER DIEM	Behavioral/Mental Health, Alcohol-Chemical Dependency	Y				
H2027	Psychoeducation	Behavioral/Mental Health, Alcohol-Chemical Dependency	Y		No prior authorization required for first 100 units per member per calendar year		
H2034	ALCOHOL AND OR DRUG ABS HALFWAY HOUSE SRVC PER DIEM	Behavioral/Mental Health, Alcohol-Chemical Dependency	Y				
H2036	ALCOHOLAND OR OTH DRUG TREATMENT PROGRAM PER DIEM	Behavioral/Mental Health, Alcohol-Chemical Dependency	Y				
S0201	PARTIAL HOSPITLZTN SERVICES UNDER 24 HR PER DIEM	Behavioral/Mental Health, Alcohol-Chemical Dependency	N		See Ky Exceptions		
S9480	INTENSIVE OP PSYCHIATRIC SERVICES PER DIEM	Behavioral/Mental Health, Alcohol-Chemical Dependency	Y		No PA required for first 16 units.		
T2023	TARGETED CASE MANAGEMENT, PER MONTH	Behavioral/Mental Health, Alcohol-Chemical Dependency	Y				
T2048	BHVAL HEALTH; LONG-TERM CARE RES W/ROOM AND BD-DIEM	Behavioral/Mental Health, Alcohol-Chemical Dependency	Y		EPSDT Special Services in Extended Care Units		
15775	PUNCH GRAFT HAIR TRANSPLANT 1-15 PUNCH GRAFTS	Cosmetic, Plastic & Reconstructive Procedures	Y				
15776	PUNCH GRAFT HAIR TRANSPLANT OVER 15 PUNCH GRAFTS	Cosmetic, Plastic & Reconstructive Procedures	Y				
15780	DERMABRASION TOTAL FACE	Cosmetic, Plastic & Reconstructive Procedures	Y				
15781	DERMABRASION SEGMENTAL FACE	Cosmetic, Plastic & Reconstructive Procedures	Y				
15782	DERMABRASION REGIONAL OTHER THAN FACE	Cosmetic, Plastic & Reconstructive Procedures	Y				
15783	DERMABRASION SUPERFICIAL ANY SITE	Cosmetic, Plastic & Reconstructive Procedures	Y				
15786	ABRASION 1 LESION	Cosmetic, Plastic & Reconstructive Procedures	Y				
15788	CHEMICAL PEEL FACIAL EPIDERMAL	Cosmetic, Plastic & Reconstructive Procedures	Y				
15789	CHEMICAL PEEL FACIAL DERMAL	Cosmetic, Plastic & Reconstructive Procedures	Y				
15792	CHEMICAL PEEL NONFACIAL EPIDERMAL	Cosmetic, Plastic & Reconstructive Procedures	Y				
15793	CHEMICAL PEEL NONFACIAL DERMAL	Cosmetic, Plastic & Reconstructive Procedures	Y				
15820	BLEPHAROPLASTY LOWER EYELID	Cosmetic, Plastic & Reconstructive Procedures	Y				
15821	BLEPHAROPLASTY LOWER EYELID HERNIATED FAT PAD	Cosmetic, Plastic & Reconstructive Procedures	Y				
15822	BLEPHAROPLASTY UPPER EYELID	Cosmetic, Plastic & Reconstructive Procedures	Y				
15823	BLEPHAROPLASTY UPPER EYELID W EXCESSIVE SKIN	Cosmetic, Plastic & Reconstructive Procedures	Y				
15824	RHYTIDECTOMY FOREHEAD	Cosmetic, Plastic & Reconstructive Procedures	Y				
15825	RHYTIDECTOMY NECK W PLATYSMAL TIGHTENING	Cosmetic, Plastic & Reconstructive Procedures	Y				
15826	RHYTIDECTOMY GLABELLAR FROWN LINES	Cosmetic, Plastic & Reconstructive Procedures	Y				
15828	RHYTIDECTOMY CHEEK CHIN AND NECK	Cosmetic, Plastic & Reconstructive Procedures	Y				
15829	RHYTIDECTOMY SMAS FLAP	Cosmetic, Plastic & Reconstructive Procedures	Y				
15830	EXCISION SKIN ABD INFRAUMBILICAL PANNICULECTOMY	Cosmetic, Plastic & Reconstructive Procedures	Y				
15832	EXCISION EXCESSIVE SKIN AND SUBQ TISSUE THIGH	Cosmetic, Plastic & Reconstructive Procedures	Y				
15833	EXCISION EXCESSIVE SKIN AND SUBQ TISSUE LEG	Cosmetic, Plastic & Reconstructive Procedures	Y				
15834	EXCISION EXCESSIVE SKIN AND SUBQ TISSUE HIP	Cosmetic, Plastic & Reconstructive Procedures	Y				
15835	EXCISION EXCESSIVE SKIN AND SUBQ TISSUE BUTTOCK	Cosmetic, Plastic & Reconstructive Procedures	Y				
15836	EXCISION EXCESSIVE SKIN AND SUBQ TISSUE ARM	Cosmetic, Plastic & Reconstructive Procedures	Y				
15837	EXC EXCESSIVE SKIN AND SUBQ TISSUE FOREARM HAND	Cosmetic, Plastic & Reconstructive Procedures	Y				
15838	EXC EXCSV SKIN AND SUBQ TISSUE SUBMENTAL FAT PAD	Cosmetic, Plastic & Reconstructive Procedures	Y				
15839	EXCISION EXCESSIVE SKIN AND SUBQ TISSUE OTHER AREA	Cosmetic, Plastic & Reconstructive Procedures	Y				
15847	EXCISION EXCESSIVE SKIN AND SUBQ TISSUE ABDOMEN	Cosmetic, Plastic & Reconstructive Procedures	Y				
15876	SUCTION ASSISTED LIPECTOMY HEAD AND NECK	Cosmetic, Plastic & Reconstructive Procedures	Y				
15877	SUCTION ASSISTED LIPECTOMY TRUNK	Cosmetic, Plastic & Reconstructive Procedures	Y				
15878	SUCTION ASSISTED LIPECTOMY UPPER EXTREMITY	Cosmetic, Plastic & Reconstructive Procedures	Y				
15879	SUCTION ASSISTED LIPECTOMY LOWER EXTREMITY	Cosmetic, Plastic & Reconstructive Procedures	Y				
17380	ELECTROLYSIS EPILATION EACH 30 MINUTES	Cosmetic, Plastic & Reconstructive Procedures	Y				
19300	MASTECTOMY GYNECOMASTIA	Cosmetic, Plastic & Reconstructive Procedures	Y		No PA required when associated with breast cancer diagnoses.		
19303	MASTECTOMY SIMPLE COMPLETE	Cosmetic, Plastic & Reconstructive Procedures	Y		No PA required when associated with breast cancer diagnoses.		
19316	MASTOPEXY	Cosmetic, Plastic & Reconstructive Procedures	Y		No PA required when associated with breast cancer diagnoses.		
19318	REDUCTION MAMMAPLASTY	Cosmetic, Plastic & Reconstructive Procedures	Y		No PA required when associated with breast cancer diagnoses.		
19325	MAMMAPLASTY AUGMENTATION W PROSTHETIC IMPLANT	Cosmetic, Plastic & Reconstructive Procedures	Y		No PA required when associated with breast cancer diagnoses.		
19328	REMOVAL INTACT MAMMARY IMPLANT	Cosmetic, Plastic & Reconstructive Procedures	Y		No PA required when associated with breast cancer diagnoses.		
19330	REMOVAL MAMMARY IMPLANT MATERIAL	Cosmetic, Plastic & Reconstructive Procedures	Y		No PA required when associated with breast cancer diagnoses.		
19340	IMMT INSJ BRST PROSTH FLWG MASTOPEXY MAST RCNSTJ	Cosmetic, Plastic & Reconstructive Procedures	Y		No PA required when associated with breast cancer diagnoses.		
19342	DLYD INSJ BRST PROSTH FLWG MASTOPEXY MAST RCNSTJ	Cosmetic, Plastic & Reconstructive Procedures	Y		No PA required when associated with breast cancer diagnoses.		
19350	NIPPLE AREOLA RECONSTRUCTION	Cosmetic, Plastic & Reconstructive Procedures	Y		No PA required when associated with breast cancer diagnoses.		
19355	CORRECTION INVERTED NIPPLES	Cosmetic, Plastic & Reconstructive Procedures	Y		No PA required when associated with breast cancer diagnoses.		
19396	PREPARATION MOULAGE CUSTOM BREAST IMPLANT	Cosmetic, Plastic & Reconstructive Procedures	Y		No PA required when associated with breast cancer diagnoses.		
30400	RHINP PRIM LAT AND ALAR CRTLGS AND ELVTN NASAL TI	Cosmetic, Plastic & Reconstructive Procedures	Y				
30410	RHINP PRIM COMPLETE XTRNL PARTS	Cosmetic, Plastic & Reconstructive Procedures	Y				
30420	RHINOPLASTY PRIMARY W MAJOR SEPTAL REPAIR	Cosmetic, Plastic & Reconstructive Procedures	Y				
30430	RHINOPLASTY SECONDARY MINOR REVISION	Cosmetic, Plastic & Reconstructive Procedures	Y				
30435	RHINOPLASTY SECONDARY INTERMEDIATE REVISION	Cosmetic, Plastic & Reconstructive Procedures	Y				
30450	RHINOPLASTY SECONDARY MAJOR REVISION	Cosmetic, Plastic & Reconstructive Procedures	Y				
30460	RHINP DFRM W COLUM LNGTH TIP ONLY	Cosmetic, Plastic & Reconstructive Procedures	Y				
30462	RHINP DFRM COLUM LNGTH TIP SEPTUM OSTEOT	Cosmetic, Plastic & Reconstructive Procedures	Y				
30468	RPR NSL VLV COLLAPSE SUBQ/SBMCSL LAT WALL IMPLT	Cosmetic, Plastic & Reconstructive Procedures	Y				
67900	REPAIR BROW PTOSIS	Cosmetic, Plastic & Reconstructive Procedures	Y				
67901	RPR BLEPHAROPTOSIS FRONTALIS MUSC SUTR OTH MATRL	Cosmetic, Plastic & Reconstructive Procedures	Y				
67902	RPR BLEPHAROPT FRONTALIS MUSC AUTOL FASCAL SLING	Cosmetic, Plastic & Reconstructive Procedures	Y				
67903	RPR BLEPHAROPTOSIS LEVATOR RESCJ ADVMNT INTERNAL	Cosmetic, Plastic & Reconstructive Procedures	Y				
67904	RPR BLEPHAROPTOSIS LEVATOR RESCJ ADVMNT XTRNL	Cosmetic, Plastic & Reconstructive Procedures	Y				
67906	RPR BLEPHAROPTOSIS SUPERIOR RECTUS FASCIAL SLING	Cosmetic, Plastic & Reconstructive Procedures	Y				
67908	RPR BLPOS CONJUNCTIVO-TARSO-MUSC-LEVATOR RESCJ	Cosmetic, Plastic & Reconstructive Procedures	Y				
67909	REDUCTION OVERCORRECTION PTOSIS	Cosmetic, Plastic & Reconstructive Procedures	Y				
67950	CANTHOPLASTY	Cosmetic, Plastic & Reconstructive Procedures	Y				
69300	OTOPLASTY PROTRUDING EAR W/WO SIZE RDCTN	Cosmetic, Plastic & Reconstructive Procedures	Y				
A4238	SPL ALW ADJ NI CGM 1 MONTH SUPPLY Equal to 1 UOS	Durable Medical Equipment (DME)	Y		No prior authorization required within product utilization limits for members with gestational or insulin-dependent diabetes (claim diagnosis must support).		
A4239	SPLY ALW NONADJUNC NONIMPL CGM 1 MO SPLY Equal to 1 UOS	Durable Medical Equipment (DME)	Y		No prior authorization required within product utilization limits for members with gestational or insulin-dependent diabetes (claim diagnosis must support).		
A4341	INDWELL IU DRAIN DEVC VLV PT INSRT REPLC ONLY EA	Durable Medical Equipment (DME)	Y				
A4342	ACC PT INS INDWELL IU DRN DEVC VLV REPLC ONLY EA	Durable Medical Equipment (DME)	Y				
A4560	NEUROMUSCULAR ELECTRICAL STIM DISP REPLC ONLY	Durable Medical Equipment (DME)	Y				
A9274	EXTERNAL AMB INSULIN DEL SYSTEM DISPOSABLE EA	Durable Medical Equipment (DME)	Y				
A9276	SENSOR;INVSV DISPSBLE INTRSTL CGM 1U EQLS 1D SPPLY	Durable Medical Equipment (DME)	Y		No prior authorization required within product utilization limits for members with gestational or insulin-dependent diabetes (claim diagnosis must support).		
A9277	TRANSMITTER; EXT INTERSTITIAL CONT GLU MON SYS	Durable Medical Equipment (DME)	Y		No prior authorization required within product utilization limits for members with gestational or insulin-dependent diabetes (claim diagnosis must support).		
A9278	RECEIVER MON; EXT INTERSTITIAL CONT GLU MON SYS	Durable Medical Equipment (DME)	Y		No prior authorization required within product utilization limits for members with gestational or insulin-dependent diabetes (claim diagnosis must support).		
B4105	IN-LINE CART CTG DIG ENZYME ENTERAL FEEDING EA	Durable Medical Equipment (DME)	Y				
C2624	IMPL WIRELESS PULM ARTERY PRESS SENSOR DEL CATH	Durable Medical Equipment (DME)	Y				
E0194	AIR FLUIDIZED BED	Durable Medical Equipment (DME)	Y				
E0255	HOSP BED VARIBL HT W ANY TYPE SIDE RAIL W MATTRSS	Durable Medical Equipment (DME)	Y				
E0260	HOSP BED SEMI-ELEC W ANY TYPE SIDE RAIL W MATTRSS	Durable Medical Equipment (DME)	Y				
E0261	HOSP BED SEMI-ELEC ANY TYPE SIDE RAIL W O MATTRSS	Durable Medical Equipment (DME)	Y				
E0265	HOSP BED TOT ELCTRC W ANY TYPE SIDE RAIL W MTTRSS	Durable Medical Equipment (DME)	Y				
E0266	HOS BED TTL ELCTRC ANY TYPE SIDE RAIL W/O MTTRSS	Durable Medical Equipment (DME)	Y				
E0277	POWERED PRESSURE-REDUCING AIR MATTRESS	Durable Medical Equipment (DME)	Y				
E0292	HOSP BED VARIBL HT HI-LO W O SIDE RAIL W MATTRSS	Durable Medical Equipment (DME)	Y				
E0293	HOSP BED VARIBL HT HI-LO W O SIDE RAIL NO MATTRSS	Durable Medical Equipment (DME)	Y				
E0294	HOSP BED SEMI-ELEC W O SIDE RAILS W MATTRSS	Durable Medical Equipment (DME)	Y				
E0295	HOSP BED SEMI-ELEC W O SIDE RAILS W O MATTRSS	Durable Medical Equipment (DME)	Y				
E0296	HOSP BED TOTAL ELEC W O SIDE RAILS W MATTRSS	Durable Medical Equipment (DME)	Y				
E0297	HOSP BED TOTAL ELEC W O SIDE RAILS W O MATTRSS	Durable Medical Equipment (DME)	Y				
E0300	PED CRIB HOS GRADE FULLY ENC W WO TOP ENC	Durable Medical Equipment (DME)	Y				
E0301	HOSP BED HVY DTY XTRA WIDE W WGHT CAPACTY OVER 350 PDS	Durable Medical Equipment (DME)	Y				
E0302	HOSP BED XTRA HVY DTY WT CAP OVER 600 PDS W O MTTRSS	Durable Medical Equipment (DME)	Y				
E0303	HOSP BED HEAVY DUTY W WT CAP OVER 350 PDS UNDER EQ TO 600	Durable Medical Equipment (DME)	Y				
E0304	HOSP BED EXTRA HEAVY DUTY WT CAP OVER 600 PDS MATTRSS	Durable Medical Equipment (DME)	Y				
E0316	SFTY ENCLOS FRME/CANOPY USE W/HOSP BED ANY TYPE	Durable Medical Equipment (DME)	Y				
E0328	HOSP BED PEDIATRIC MANUAL INCLUDES MATTRESS	Durable Medical Equipment (DME)	Y				
E0329	HOSP BED PEDIATRIC ELECTRIC INCLUDE MATTRESS	Durable Medical Equipment (DME)	Y				
E0371	NONPWR ADV PRSS RDUC OVRLAY MATTRSS STD LEN AND WDTH	Durable Medical Equipment (DME)	Y				
E0372	PWR AIR OVRLAY MATTRSS STD MATTRSS LENGTH AND WIDTH	Durable Medical Equipment (DME)	Y				
E0373	NONPOWERED ADVANCD PRESSURE REDUCING MATTRESS	Durable Medical Equipment (DME)	Y				
E0462	ROCKING BED WITH OR WITHOUT SIDE RAILS	Durable Medical Equipment (DME)	Y				
E0465	HOME VENTILATOR ANY TYPE USED W INVASIVE INTF	Durable Medical Equipment (DME)	Y				
E0466	HOME VENTILATOR ANY TYPE USED W NON-INVASIV INTF	Durable Medical Equipment (DME)	Y				
E0467	HOME VENTILATOR MULTI-FUNCTION RESPIRATORY DEVC	Durable Medical Equipment (DME)	Y				
E0468	HOME VENT DF RESP DVC PER ADD FUNC OF COUGH STIM	Durable Medical Equipment (DME)	Y				
E0470	RESP ASST DEVC BI-LEVL PRSS CAPABILITY W/O BACKU	Durable Medical Equipment (DME)	Y				
E0471	RESP ASST DEVC BI-LEVL PRSS CAPABILITY W/BACK-UP	Durable Medical Equipment (DME)	Y				
E0472	RESP ASST DEVC BI-LEVL PRSS CAPABILITY W/BACKUP	Durable Medical Equipment (DME)	Y				
E0481	INTRAPULM PERCUSSIVE VENT SYSTEM AND REL ACSSORIES	Durable Medical Equipment (DME)	Y				
E0483	HI FREQNCY CHEST WALL OSCILLATION SYSTEM EA	Durable Medical Equipment (DME)	Y				
E0486	ORL DEVC/APPL RDUC UP AIRWAY COLLAPSIBILITY CSTM	Durable Medical Equipment (DME)	Y				
E0492	PS AND CTRL ELEC U O DVC/APPL NM ELEC STIM TNG M	Durable Medical Equipment (DME)	Y				
E0493	ORAL DEVICE/APPL NM ELEC STIM TONGUE MUSCLE	Durable Medical Equipment (DME)	Y				
E0637	COMB SIT STAND FRAME/TABLE SYS SEATLIFT FEATURE	Durable Medical Equipment (DME)	Y				
E0638	STANDING FRAME/TABLE SYS ONE PSTION ANY SZ W/WO WHLS	Durable Medical Equipment (DME)	Y				
E0640	PATIENT LIFT FIX SYS INCLUDES ALL CMPNTS/ACCESS	Durable Medical Equipment (DME)	Y				
E0641	FORM-FITTING CONDUCTIVE GARMENT DELIV TENS/NMES	Durable Medical Equipment (DME)	Y				
E0642	STANDING FRAME/TABLE SYS MOBILE DYNAMIC ANY SZ	Durable Medical Equipment (DME)	Y				
E0652	PNEUMAT COMPRS SEG HOM MDL W/CALBRTD GRADNT PRSS	Durable Medical Equipment (DME)	Y				
E0656	SEG PNEUMAT APPLIANCE USE W PNEUMAT COMPRS TRUNK	Durable Medical Equipment (DME)	Y				
E0667	SEG PNEUMAT APPLINC W PNEUMAT COMPRS FULL LEG	Durable Medical Equipment (DME)	Y				
E0668	SEG PNEUMAT APPLINC W PNEUMAT COMPRS FULL ARM	Durable Medical Equipment (DME)	Y				
E0671	SEGMENTAL GRADIENT PRESS PNEUMAT APPLINC FULL LEG	Durable Medical Equipment (DME)	Y				
E0675	PNEUMAT COMPRS DEVC HI PRSS RAPID INFLATION DEFL	Durable Medical Equipment (DME)	Y				
E0676	INTERMITTENT LIMB COMPRESSION DEVICE NOS	Durable Medical Equipment (DME)	Y				
E0677	NONPNEUMATIC SEQUENTIAL COMP GARMENT TRUNK	Durable Medical Equipment (DME)	Y				
E0691	UV LIGHT TX SYS BULB LAMP TIMER; TX 2 SQ FT LESS	Durable Medical Equipment (DME)	Y				
E0692	UV LT TX SYS PANL W BULB LAMP TIMER 4 FT PANEL	Durable Medical Equipment (DME)	Y				
E0693	UV LT TX SYS PANL W BULBS LAMPS TIMER 6 FT PANEL	Durable Medical Equipment (DME)	Y				
E0694	UV MX DIR LT TX SYS 6 FT CABINET W BULB LAMP TMR	Durable Medical Equipment (DME)	Y				
E0747	OSTOGNS STIM ELEC NONINVASV OTH THAN SP APPLIC	Durable Medical Equipment (DME)	Y				

E0748	OSTOGNS STIMULATOR ELEC NONINVASV SPINAL APPLIC	Durable Medical Equipment (DME)	Y				
E0749	OSTEOGENESIS STIMULATOR ELEC SURGICALLY IMPL	Durable Medical Equipment (DME)	Y				
E0760	OSTOGNS STIM LOW INTENS ULTRASOUND NON-INVASV	Durable Medical Equipment (DME)	Y				
E0762	TRANSCUT ELEC JOINT STIM DEVC SYS INCL ALL ACCSS	Durable Medical Equipment (DME)	Y				
E0764	FUNC NEUROMUSC STIM MUSC AMBUL CMPT CNTRL SC INJ	Durable Medical Equipment (DME)	Y				
E0766	ELEC STIM DVC U CANCER TX INCL ALL ACC ANY TYPE	Durable Medical Equipment (DME)	Y				
E0782	INFUSION PUMP IMPLANTABLE NON-PROGRAMMABLE	Durable Medical Equipment (DME)	Y				
E0783	INFUSION PUMP SYSTEM IMPLANTABLE PROGRAMMABLE	Durable Medical Equipment (DME)	Y				
E0784	EXTERNAL AMBULATORY INFUSION PUMP INSULIN	Durable Medical Equipment (DME)	Y				
E0785	IMPLANTABLE INTRASPINL CATHETER USED W PUMP-REPL	Durable Medical Equipment (DME)	Y				
E0786	IMPLANTABLE PROGRAMMABLE INFUSION PUMP REPL	Durable Medical Equipment (DME)	Y				
E0787	EXTERNAL AMB INFUS PUMP INSULIN DOS RATE ADJ	Durable Medical Equipment (DME)	Y				
E0983	MNL WC ACSS PWR ADD-ON CONVRT MNL WC MOTRIZD WC JOYST CNTRL	Durable Medical Equipment (DME)	Y				
E0984	MNL WC ACSS PWR ADD-ON CONVRT MNL WC MOTRIZD WC TILLER CNTRL	Durable Medical Equipment (DME)	Y				
E0986	MNL WHEELCHAIR ACSS PUSH-RIM ACT PWR ASSIST SYS	Durable Medical Equipment (DME)	Y				
E0988	MANUAL WC ACCESSORY LEVR-ACTIVATD WHL DRIVE PAIR	Durable Medical Equipment (DME)	Y				
E1002	WHEELCHAIR ACCESS POWER SEATING SYSTEM TILT ONLY	Durable Medical Equipment (DME)	Y				
E1003	WC ACSS PWR SEAT SYS RECLINE W O SHEAR RDUC	Durable Medical Equipment (DME)	Y				
E1004	WC ACSS PWR SEAT SYS RECLINE W MECH SHEAR RDUC	Durable Medical Equipment (DME)	Y				
E1005	WC ACSS PWR SEAT SYS RECLINE W PWR SHEAR RDUC	Durable Medical Equipment (DME)	Y				
E1006	WC ACSS PWR SEAT SYS TILT AND RECLINE NO SHEAR RDUC	Durable Medical Equipment (DME)	Y				
E1007	WC ACSS PWR SEAT TILT AND RECLINE MECH SHEAR RDUC	Durable Medical Equipment (DME)	Y				
E1008	WC ACSS PWR SEAT TILT AND RECLINE W PWR SHEAR RDUC	Durable Medical Equipment (DME)	Y				
E1010	WC ACCSS ADD PWR SEAT SYS PWR LEG ELEV SYS PAIR	Durable Medical Equipment (DME)	Y				
E1012	WC ACCSS PWR SEAT SYS CNTR MNT PWR ELEV LEG EA	Durable Medical Equipment (DME)	Y				
E1030	WHEELCHAIR ACCESSORY VENTILATOR TRAY GIMBALED	Durable Medical Equipment (DME)	Y				
E1161	MANUAL ADULT SIZE WHEELCHAIR INCLUDES TILT SPACE	Durable Medical Equipment (DME)	Y				
E1229	WHEELCHAIR PEDIATRIC SIZE NOS	Durable Medical Equipment (DME)	Y				
E1230	PWR OPERATED VEH SPEC BRAND NAME AND MODEL NUMBER	Durable Medical Equipment (DME)	Y				
E1232	WC PED SZ TILT-IN-SPACE FOLD ADJUSTBL W SEAT SYS	Durable Medical Equipment (DME)	Y				
E1233	WC PED SZ TILT-IN-SPACE RIGD ADJUSTBL W O SEAT	Durable Medical Equipment (DME)	Y				
E1234	WC PED SZ TILT-IN-SPACE FOLD ADJUSTBL W O SEAT	Durable Medical Equipment (DME)	Y				
E1235	WHLCHAIR PED SIZE RIGD ADJUSTBL W SEATING SYSTEM	Durable Medical Equipment (DME)	Y				
E1236	WHLCHAIR PED SIZE FOLD ADJUSTBL W SEATING SYSTEM	Durable Medical Equipment (DME)	Y				
E1237	WHLCHAIR PED SZ RIGD ADJUSTBL W O SEATING SYSTEM	Durable Medical Equipment (DME)	Y				
E1238	WHLCHAIR PED SZ FOLD ADJUSTBL W O SEATING SYSTEM	Durable Medical Equipment (DME)	Y				
E1310	WHIRLPOOL NONPORTABLE	Durable Medical Equipment (DME)	Y				
E1905	VIRTUAL REALITY CBT INCLUDING PP TX SOFTWARE	Durable Medical Equipment (DME)	Y				
E2102	ADJUNCTIVE CONTINUOUS GLUCOSE MONITOR/RECEIVER	Durable Medical Equipment (DME)	Y		No prior authorization required within product utilization limits for members with gestational or insulin-dependent diabetes (claim diagnosis must support).		
E2103	NONADJUNCTIVE NONIMPLANTED CGM/RECEIVER	Durable Medical Equipment (DME)	Y		No prior authorization required within product utilization limits for members with gestational or insulin-dependent diabetes (claim diagnosis must support).		
E2295	MNL WC ACCESS PED SIZE WC DYNAMIC SEATING FRAME	Durable Medical Equipment (DME)	Y				
E2298	COMPLEX REHAB PWR WC ACC PWR SEAT EL SYS ANY TYP	Durable Medical Equipment (DME)	Y				
E2301	WHEELCHAIR ACCESSORY POWER STANDING SYS ANY TYPE	Durable Medical Equipment (DME)	Y				
E2310	PWR WC ACSS ELEC CNCT BETWN WC CNTRLLER AND ONE PWR	Durable Medical Equipment (DME)	Y				
E2311	PWR WC ACSS ELEC CNCT BETWN WC CNTRLLER AND TWO MORE	Durable Medical Equipment (DME)	Y				
E2312	POWER WC ACCESS HAND OR CHIN CONTROL INTERFACE	Durable Medical Equipment (DME)	Y				
E2313	POWER WC ACCESS HARNESS UPGRADE EXP CONTROLLR EA	Durable Medical Equipment (DME)	Y				
E2321	PWR WC ACSS HND CNTRL REMOT JOYSTCK NO PRPRTNL	Durable Medical Equipment (DME)	Y				
E2322	PWR WC ACSS HND CNTRL MX MECH SWTCH NO PRPRTNL	Durable Medical Equipment (DME)	Y				
E2325	PWR WC ACSS SIP AND PUFF INTERFCE NONPROPRTNAL	Durable Medical Equipment (DME)	Y				
E2327	PWR WC ACSS HEAD CNTRL INTERFCE MECH PROPRTNAL	Durable Medical Equipment (DME)	Y				
E2328	PWR WC ACSS HEAD CNTRL EXT CNTRL ELEC PRPRTNL	Durable Medical Equipment (DME)	Y				
E2329	PWR WC ACSS HEAD CNTRL CNTC SWTCH MECH NOPRPRTNL	Durable Medical Equipment (DME)	Y				
E2330	PWR WC ACCSS HEAD PROX SWITCH MECH NONPRPRTNL	Durable Medical Equipment (DME)	Y				
E2340	POWER WC ACCESS NONSTAND SEAT FRAME WD 20-23 IN	Durable Medical Equipment (DME)	Y				
E2341	PWR WC ACSS NONSTD SEAT FRME WIDTH 24-27 IN	Durable Medical Equipment (DME)	Y				
E2342	PWR WC ACSS NONSTD SEAT FRME DEPTH 20 21 IN	Durable Medical Equipment (DME)	Y				
E2343	PWR WC ACSS NONSTD SEAT FRME DEPTH 22-25 IN	Durable Medical Equipment (DME)	Y				
E2351	PWR WC ACSS ELEC INTERFCE OPERATE SPCH GEN DEVC	Durable Medical Equipment (DME)	Y				
E2369	POWER WC CMPNNT DRIVE WHEEL GEAR BOX REPL ONLY	Durable Medical Equipment (DME)	Y				
E2370	PWR WC COMP INT DR WHL MTR AND GR BOX COMB REPL ONLY	Durable Medical Equipment (DME)	Y				
E2373	PWR WC MINI-PROPORTIONAL COMPACT REMOTE JOYSTICK	Durable Medical Equipment (DME)	Y				
E2375	PWR WC NONEXPNDABLE CONTROLLER REPLACEMENT ONLY	Durable Medical Equipment (DME)	Y				
E2376	PWR WC EXPANDABLE CONTROLLER REPLACEMENT ONLY	Durable Medical Equipment (DME)	Y				
E2377	PWR WC EXPANDABLE CONTROLLER UPGRADE INIT ISSUE	Durable Medical Equipment (DME)	Y				
E2398	WHEELCHAIR ACC, DYNAMIC POS HARDWARE FOR BACK	Durable Medical Equipment (DME)	Y				
E2402	NEG PRESS WOUND THERAPY ELEC PUMP STATION/PRTBLE	Durable Medical Equipment (DME)	Y				
E2500	SPEECH GEN DEVC DIGITIZED UNDER EQ 8 MINS REC TIME	Durable Medical Equipment (DME)	Y				
E2502	SPCH GEN DEVC DIGTIZD OVER 8 MINS LESS THN EQ 20 MIN REC	Durable Medical Equipment (DME)	Y				
E2504	SPCH GEN DEVC DIGTIZD OVER 20 MINS UNDER EQ 40 MINS REC	Durable Medical Equipment (DME)	Y				
E2506	SPEECH GEN DEVICE DIGITIZED OVER 40 MINS REC TIME	Durable Medical Equipment (DME)	Y				
E2508	SPCH GEN DEVC SYNTHSIZD REQ MESS SPELL AND CNTCT	Durable Medical Equipment (DME)	Y				
E2510	SPCH GEN DEVC SYNTHESIZD MX METH MESS AND DEVC ACCSS	Durable Medical Equipment (DME)	Y				
E2511	SPEECH GEN SOFTWARE PROG PC PERS DIGITAL ASSIST	Durable Medical Equipment (DME)	Y				
E2512	ACCESS SPEECH GENERATING DEVICE MOUNTING SYSTEM	Durable Medical Equipment (DME)	Y				
E2599	ACCESSORY FOR SPEECH GENERATING DEVICE NOC	Durable Medical Equipment (DME)	Y				
E2609	CUSTOM FABRICATED WHEELCHAIR SEAT CUSHION SIZE	Durable Medical Equipment (DME)	Y				
E2617	CSTM FAB WC BACK CUSHN ANY SZ ANY MOUNT HARDWARE	Durable Medical Equipment (DME)	Y				
E2626	WC ACCESS SHLDR ELB MOBIL ARM SUPP WC ADJUSTBLE	Durable Medical Equipment (DME)	Y				
E2628	WC ACCESS SHLDR ELB MOBIL ARM SUPP WC RECLINING	Durable Medical Equipment (DME)	Y				
E2629	WC ACCESS SHLDR ELB M ARM SUPP FRICTION ARM SUPP	Durable Medical Equipment (DME)	Y				
K0005	ULTRALIGHTWEIGHT WHEELCHAIR	Durable Medical Equipment (DME)	Y				
K0008	CUSTOM MANUAL WHEELCHAIR BASE	Durable Medical Equipment (DME)	Y				
K0009	OTHER MANUAL WHEELCHAIR/BASE	Durable Medical Equipment (DME)	Y				
K0010	STANDARD-WEIGHT FRAME MOTORIZED POWER WHEELCHAIR	Durable Medical Equipment (DME)	Y				
K0011	STD-WT FRME MOTRIZD PWR WHLCHAIR W PROG CNTRL	Durable Medical Equipment (DME)	Y				
K0012	LIGHTWEIGHT PORTABLE MOTORIZED POWER WHEELCHAIR	Durable Medical Equipment (DME)	Y				
K0013	CUSTOM MOTORIZED POWER WHEELCHAIR BASE	Durable Medical Equipment (DME)	Y				
K0014	OTHER MOTORIZED POWER WHEELCHAIR BASE	Durable Medical Equipment (DME)	Y				
K0108	OTHER ACCESSORIES	Durable Medical Equipment (DME)	Y				
K0606	AUTO EXT DEFIB W INTGR ECG ANALY GARMENT TYPE	Durable Medical Equipment (DME)	Y				
K0800	PWR OP VEH GRP 1 STD PT WT CAP TO AND INCL 300 LBS	Durable Medical Equipment (DME)	Y				
K0801	PWR OP VEH GRP 1 HEAVY DUTY PT 301 TO 450 LBS	Durable Medical Equipment (DME)	Y				
K0802	PWR OP VEH GRP 1 VERY HEAVY DUTY PT 451-600 LBS	Durable Medical Equipment (DME)	Y				
K0806	PWR OP VEH GRP 2 STD PT WT CAP TO AND INCL 300 LBS	Durable Medical Equipment (DME)	Y				
K0807	PWR OP VEH GRP 2 HEAVY DUTY PT 301 TO 450 LBS	Durable Medical Equipment (DME)	Y				
K0808	PWR OP VEH GRP 2 VERY HEAVY DUTY PT 451-600 LBS	Durable Medical Equipment (DME)	Y				
K0813	PWR WC GRP 1 STD PORT SLING SEAT PT TO 300 LBS	Durable Medical Equipment (DME)	Y				
K0814	PWR WC GRP 1 STD PORT CAPT CHAIR PT TO 300 LBS	Durable Medical Equipment (DME)	Y				
K0815	PWR WC GRP 1 STD SLING SEAT PT UP TO AND EQ 300 LBS	Durable Medical Equipment (DME)	Y				
K0816	PWR WC GRP 1 STD CAPTAINS CHAIR PT TO AND EQ 300 LBS	Durable Medical Equipment (DME)	Y				
K0820	PWR WC GRP 2 STD PORT SLING SEAT PT TO AND EQ 300 LBS	Durable Medical Equipment (DME)	Y				
K0821	PWR WC GRP 2 STDRD PORT CAPT CHAIR PT UPTO INCLDNG 300 LBS	Durable Medical Equipment (DME)	Y				
K0822	PWR WC GRP 2 STD SLING SEAT PT TO AND EQ 300 LBS	Durable Medical Equipment (DME)	Y				
K0823	PWR WC GRP 2 STD CAPTAINS CHAIR PT TO & EQ 300 LBS	Durable Medical Equipment (DME)	Y				
K0824	PWR WC GRP 2 HEVY DUTY SLING SEAT PT 301-450 LBS	Durable Medical Equipment (DME)	Y				
K0825	PWR WC GRP 2 HEVY DUTY CAPT CHAIR PT 301-450 LBS	Durable Medical Equipment (DME)	Y				
K0826	PWR WC GRP 2 VRY HVY DTY SLNG SEAT PT 451-600 LB	Durable Medical Equipment (DME)	Y				
K0827	PWR WC GRP 2 VRY HVY DTY CAPT CHR PT 451-600 LBS	Durable Medical Equipment (DME)	Y				
K0828	PWR WC GRP 2 XTRA HVY DUTY SLING SEAT PT 601LB OR GRT	Durable Medical Equipment (DME)	Y				
K0829	PWR WC GRP 2 XTRA HVY DUTY CHAIR PT 601 LBS OR GRT	Durable Medical Equipment (DME)	Y				
K0830	PWR WC GRP 2 STD SEAT ELEV SLING PT TO AND EQ 300 LBS	Durable Medical Equipment (DME)	Y				
K0831	PWR WC GRP 2 STD SEAT ELEV CAP CHR PT TO 300 LB	Durable Medical Equipment (DME)	Y				
K0835	PWR WC GRP 2 STD 1 PWR SLING SEAT PT TO 300 LBS	Durable Medical Equipment (DME)	Y				
K0836	PWR WC GRP 2 STD 1 PWR CAPT CHAIR PT TO 300 LBS	Durable Medical Equipment (DME)	Y				
K0837	PWR WC GRP 2 HVY 1 PWR SLING SEAT PT 301-450 LBS	Durable Medical Equipment (DME)	Y				
K0838	PWR WC GRP 2 HVY 1 PWR CAPT CHAIR PT 301-450 LBS	Durable Medical Equipment (DME)	Y				
K0839	PWR WC GRP 2 VRY HVY 1 PWR SLING PT 451-600 LBS	Durable Medical Equipment (DME)	Y				
K0840	PWR WC GRP 2 XTRA HVY 1 PWR SLING PT 601 LBS OR MORE	Durable Medical Equipment (DME)	Y				
K0841	PWR WC GRP 2 MX PWR SLING SEAT PT TO AND EQ 300 LBS	Durable Medical Equipment (DME)	Y				
K0842	PWR WC GRP 2 STD MX PWR CAPT CHR PT WT UPTO AND INCLDNG 300 LBS	Durable Medical Equipment (DME)	Y				
K0843	PWR WC GRP 2 HVY MX PWR SLNG SEAT PT 301-450 LBS	Durable Medical Equipment (DME)	Y				
K0848	PWR WC GRP 3 STD SLING SEAT PT TO AND EQ 300 LBS	Durable Medical Equipment (DME)	Y				
K0849	PWR WC GRP 3 STD CAPTAIN CHAIR PT TO AND EQ 300 LBS	Durable Medical Equipment (DME)	Y				
K0850	PWR WC GRP 3 HVY DUTY SLING SEAT PT 301-450 LBS	Durable Medical Equipment (DME)	Y				
K0851	PWR WC GRP 3 HVY DUTY CAPT CHAIR PT 301-450 LBS	Durable Medical Equipment (DME)	Y				
K0852	PWR WC GRP 3 V HVY DUTY SLING SEAT PT 451-600 LB	Durable Medical Equipment (DME)	Y				
K0853	PWR WC GRP 3 HVY DUTY CAPT CHAIR PT 451-600 LBS	Durable Medical Equipment (DME)	Y				
K0854	PWR WC GRP 3 XTRA HVY DTY SLNG SEAT PT 601 LBS OR GRT	Durable Medical Equipment (DME)	Y				
K0855	PWR WC GRP 3X HVY DTY CHR PT WT CAP 601 LB OR GRT	Durable Medical Equipment (DME)	Y				
K0856	PWR WC GRP 3 STD 1 PWR SLING SEAT PT TO AND EQ 300 LB	Durable Medical Equipment (DME)	Y				
K0857	PWR WC GRP 3 STD 1 PWR CAPT CHAIR PT TO AND EQ 300 LB	Durable Medical Equipment (DME)	Y				
K0858	PWR WC GRP 3 HD 1 PWR SLING SEAT PT 301-450 LBS	Durable Medical Equipment (DME)	Y				
K0859	PWR WC GRP 3 HD 1 PWR CAPT CHAIR PT 301-450 LBS	Durable Medical Equipment (DME)	Y				
K0860	PWR WC GRP 3 V HD 1 PWR SLING SEAT PT 451-600 LB	Durable Medical Equipment (DME)	Y				
K0861	PWR WC GRP 3 STD MX PWR SLNG SEAT PT TO AND EQ 300 LB	Durable Medical Equipment (DME)	Y				
K0862	PWR WC GRP 3 HD MX PWR SLING SEAT PT 301-450 LBS	Durable Medical Equipment (DME)	Y				
K0863	PWR WC GRP 3 V HD MX PWR SLNG SEAT PT 451-600 LB	Durable Medical Equipment (DME)	Y				
K0864	PWR WC GRP 3 XTR HD MX PWR SLNG SEAT PT 601 LB OR GRT	Durable Medical Equipment (DME)	Y				
K0868	PWR WC GRP 4 STD SLING SEAT PT TO AND EQ 300 LBS	Durable Medical Equipment (DME)	Y				
K0869	PWR WC GRP 4 STD CAPTAIN CHAIR PT TO AND EQ 300 LBS	Durable Medical Equipment (DME)	Y				
K0870	PWR WC GRP 4 HVY DUTY SLING SEAT PT 301-450 LBS	Durable Medical Equipment (DME)	Y				
K0871	PWR WC GRP 4 V HVY DUTY SLING SEAT PT 451-600 LB	Durable Medical Equipment (DME)	Y				
K0877	PWR WC GRP 4 STD 1 PWR SLING SEAT PT TO AND EQ 300 LB	Durable Medical Equipment (DME)	Y				
K0878	PWR WC GRP 4 STD 1 PWR CAPT CHAIR PT TO AND EQ 300 LB	Durable Medical Equipment (DME)	Y				
K0879	PWR WC GRP 4 HD 1 PWR SLING SEAT PT 301-450 LBS	Durable Medical Equipment (DME)	Y				
K0880	PWR WC GRP 4 V HD 1 PWR SLING SEAT PT 451-600 LB	Durable Medical Equipment (DME)	Y				
K0884	PWR WC GRP 4 STD MX PWR SLNG SEAT PT TO AND EQ 300 LB	Durable Medical Equipment (DME)	Y				
K0885	PWR WC GRP 4 STD MX PWR CAPT CHR PT TO AND EQ 300 LBS	Durable Medical Equipment (DME)	Y				
K0886	PWR WC GRP 4 HD MX PWR SLING SEAT PT 301-450 LBS	Durable Medical Equipment (DME)	Y				
K0890	PWR WC GRP 5 PED 1 PWR SLING SEAT PT TO AND EQ 125 LB	Durable Medical Equipment (DME)	Y				
K0891	PWR WC GRP 5 PED MX PWR SLNG SEAT PT TO AND EQ 125 LB	Durable Medical Equipment (DME)	Y				
K0900	CUSTOMIZED DME OTHER THAN WHEELCHAIR	Durable Medical Equipment (DME)	Y				
K1004	LW FRQ U S DIA TX DVC HM USE INCL CMPNT ANDACCESS	Durable Medical Equipment (DME)	Y				
K1007	BLTRL HKAFO DEVC PWR INCL PELVC COMPNTS UP KNEE JOINTS	Durable Medical Equipment (DME)	Y				
K1027	ORAL DEV/APPL RED U AW COL WO F MCH HNG CSTM FAB	Durable Medical Equipment (DME)	Y				
Q0480	DRIVER PNEUMATIC VAD, REP	Durable Medical Equipment (DME)	Y				
S1034	ARTIF PANCREAS DEVC SYS THAT CMNCT W ALL DEVC	Durable Medical Equipment (DME)	Y				
S1035	SENSOR; INVASV DSPBL USE ARTIF PANCREAS DEVC SYS	Durable Medical Equipment (DME)	Y				
S1036	TRANSMITTER; EXT USE W ARTIF PANCREAS DEVC SYS	Durable Medical Equipment (DME)	Y				
S1037	RECEIVER; EXTERNAL USE W ARTIF PANCREAS DEVC SYS	Durable Medical Equipment (DME)	Y				
V5171	HEARING AID CONTRALAT ROUT DEVICE MONAURAL ITE	Durable Medical Equipment (DME)	Y				
V5172	HEARING AID CONTRALAT ROUT DEVICE MONAURAL ICT	Durable Medical Equipment (DME)	Y				
V5181	HEARING AID CONTRALATERAL ROUT DVC MONAURAL BTE	Durable Medical Equipment (DME)	Y				
V5211	HEARING AID CNTRLTRL ROUTE SYS BINAURAL ITE/ITE	Durable Medical Equipment (DME)	Y				
V5212	HEARING AID CONTRALAT ROUT SYS BINAURAL ITE ITC	Durable Medical Equipment (DME)	Y				
V5213	HEARNG AID CONTRLTRL ROUT SYS BINAURAL ITE/BTE	Durable Medical Equipment (DME)	Y				
V5214	HEARING AID CONTRALAT ROUT SYS BINAURAL ITC ITC	Durable Medical Equipment (DME)	Y				
V5215	HEARING AID CONTRALAT ROUT SYS BINAURAL ITC BTE	Durable Medical Equipment (DME)	Y				
V5221	HEARING AID CONTRLTRL ROUT SYS BINAURAL BTE/BTE	Durable Medical Equipment (DME)	Y				
27412	AUTOLOGOUS CHONDROCYTE IMPLANTATION KNEE	Experimental/Investigational	Y				
27415	OSTEOCHONDRAL ALLOGRAFT KNEE OPEN	Experimental/Investigational	Y				
27416	OSTEOCHONDRAL AUTOGRAFT KNEE OPEN MOSAICPLASTY	Experimental/Investigational	Y				
31242	NASAL/SINUS NDSC DSTRJ RF ABLATION PST NSL NRV	Experimental/Investigational	Y				

31243	NASAL/SINUS NDSC DSTRJ CRYOABLATION PST NSL NRV	Experimental/Investigational	Y				
43290	ESPHGGSTRODUDNSCPY, FLXIBL, TRNSORAL; WITH DPLYMNT OF INTRGASTRIC BARIATRIC BALLON	Experimental/Investigational	Y				
46948	LIGATION HEMORRHOID BUNDLE W US	Experimental/Investigational	Y				
93702	BIS EXTRACELLULAR FLUID ALYS LYMPHEDEMA ASSMNT	Experimental/Investigational	Y				
0101T	EXTRCORPL SHOCK WAVE MUSCSKLTL NOS HIGH ENERGY	Experimental/Investigational	Y				
0206U	NEURO ALZHEIMER CELL AGGREGJ	Experimental/Investigational	Y				
0207U	NEURO ALZHEIMER QUAN IMAGING	Experimental/Investigational	Y				
0214T	NJX DX THER PARAVER FCT JT W US CER THOR 2ND LVL	Experimental/Investigational	Y				
0215T	NJX PARAVERTBRL FACET JT W US CER THOR 3RD AND OVER LVL	Experimental/Investigational	Y				
0216T	NJX DX THER PARAVER FCT JT W US LUMB SAC 1 LVL	Experimental/Investigational	Y				
0217T	NJX DX THER PARAVER FCT JT W US LUMB SAC LVL 2	Experimental/Investigational	Y				
0218T	NJX PARAVERTBRL FCT JT W US LUMB SAC 3RD AND OVER LVL	Experimental/Investigational	Y				
0274T	PERC LAMINO- LAMINECTOMY IMAGE GUIDE CERV THORAC	Experimental/Investigational	Y				
0275T	PERC LAMINO- LAMINECTOMY INDIR IMAG GUIDE LUMBAR	Experimental/Investigational	Y				
0278T	TRNSCUT ELECT MODLATION PAIN REPROCES EA TX SESS	Experimental/Investigational	Y				
0479T	FRACTIONAL ABL LSR FENESTRATION FIRST 100 SQCM	Experimental/Investigational	Y				
0483T	TMVI W PROSTHETIC VALVE PERCUTANEOUS APPROACH	Experimental/Investigational	Y				
0484T	TMVI W PROSTHETIC VALVE TRANSTHORACIC EXPOSURE	Experimental/Investigational	Y				
0488T	DIABETES PREV ONLINE ELECTRONIC PRGRM PR 30 DAYS	Experimental/Investigational	Y				
0565T	AUTOL CELL IMPLT ADPS TISS HRVG CELL IMPLT CRTJ	Experimental/Investigational	Y				
0566T	AUTOL CELL IMPLT ADPS TISS NJX IMPLT KNEE UNI	Experimental/Investigational	Y				
0569T	TTVR PERCUTANEOUS APPROACH INITIAL PROSTHESIS	Experimental/Investigational	Y				
0570T	TTVR PERCUTANEOUS APPROACH EACH ADDL PROSTHESIS	Experimental/Investigational	Y				
0738T	TX PLANNING MAG FLD INDCTJ ABLTJ MAL PRSTE TISS	Experimental/Investigational	Y				
0770T	VIRTUAL REALITY TECHNOLOGY TO ASSIST THERAPY	Experimental/Investigational	Y				
0771T	VR PX DISSOC SVC SAME PHYS/QHP 1ST 15 MIN 5YR/>	Experimental/Investigational	Y				
0772T	VR PX DISSOC SVC SAME PHYS/QHP EA ADDL 15 MIN	Experimental/Investigational	Y				
0773T	VR PX DISSOC SVC OTH PHYS/QHP 1ST 15 MIN 5YR/>	Experimental/Investigational	Y				
0774T	VR PX DISSOC SVC OTHER PHYS/QHP EA ADDL 15 MIN	Experimental/Investigational	Y				
0776T	THERAPEUTIC INDUCTION OF INTRA-BRAIN HYPOTHERMIA	Experimental/Investigational	Y				
0777T	R-T PRESSURE SENSING EPIDURAL GUIDANCE SYSTEM	Experimental/Investigational	Y				
0778T	SMMG CNCRNT APPL IMU SNR MEAS ROM POST GAIT MUSC	Experimental/Investigational	Y				
0779T	GI MYOELECTRICAL ACTIVITY STUDY STMCH-COLON I&R	Experimental/Investigational	Y				
0781T	BRNCHSC RF DSTRJ PULM NRV BI MAINSTEM BRONCHI	Experimental/Investigational	Y				
0782T	BRNCHSC RF DSTRJ PULM NRV UNI MAINSTEM BRONCHUS	Experimental/Investigational	Y				
0783T	TC AURICULAR NSTIMJ SETUP CALIBRATION &PT EDUCAJ	Experimental/Investigational	Y				
0793T	PERQ TCAT THRM ABLTJ NERVES INNERVATING P-ART	Experimental/Investigational	Y				
0794T	PT SPEC ALG RANKING PHARMACOONCOLOGIC TX OPTIONS	Experimental/Investigational	Y				
0795T	TCAT INSJ PERM DUAL CHAMBER LDLS PM COMPL SYS	Experimental/Investigational	Y				
0796T	TCAT INSJ PERM 2CHMBR LDLS PM R ATR PM COMPNT D	Experimental/Investigational	Y				
0797T	TCAT INSJ PERM 2CHMBR LDLS PM R VENTR PM COMPNT	Experimental/Investigational	Y				
0798T	TCAT RMVL PERM DUAL CHAMBER LDLS PM COMPL SYS	Experimental/Investigational	Y				
0799T	TCAT RMVL PERM 2CHMBR LDLS PM R ATR PM COMPNT	Experimental/Investigational	Y				
0800T	TCAT RMVL PERM 2CHMBR LDLS PM R VENTR PM COMPNT	Experimental/Investigational	Y				
0801T	TCAT RMVL&RPLCMT PERM 2CHMBR LDLS PM 2CHMBR SYS	Experimental/Investigational	Y				
0802T	TCAT RMVL&RPLCMT PERM 2CHMBR LDLS PM R ATR CMPNT	Experimental/Investigational	Y				
0803T	TCAT RMVL&RPLCMT PRM 2CHMBR LDLS PM R VNTR CMPNT	Experimental/Investigational	Y				
0805T	TCAT SUPR&IVC PROSTC VLV IMPLTJ PERQ FEM VN APPR D	Experimental/Investigational	Y				
0806T	TCAT SUPR&IVC PROSTC VLV IMPLTJ OPEN FEM VN APPR	Experimental/Investigational	Y				
0868T	HIGH-RESOLUTION GASTRIC ELECTROPHYSIOLOGY MAPG	Experimental/Investigational	Y				
A4563	RECTAL CNTRL SYS VAG INSRT LT USE ANY TYPE EA	Experimental/Investigational	Y				
C9782	BLD PROC NYHA CLS II/III HF/CCS CLS III/IV CRA	Experimental/Investigational	Y				
C9784	ENDO SLEEVE GASTRO W/TUBE	Experimental/Investigational	Y				
C9785	ENDO OUTLET RESTRICT W/TUBE	Experimental/Investigational	Y				
81120	IDH1 COMMON VARIANTS	Genetic Counseling & Testing	Y				
81121	IDH2 COMMON VARIANTS	Genetic Counseling & Testing	Y				
81161	DMD DUPLICATION DELETION ANALYSIS	Genetic Counseling & Testing	Y				
81162	BRCA1 BRCA2 GENE ALYS FULL SEQ FULL DUP DEL ALYS	Genetic Counseling & Testing	Y				
81163	BRCA1 BRCA2 GENE ANALYSIS FULL SEQUENCE ANALYSIS	Genetic Counseling & Testing	Y				
81164	BRCA1 BRCA2 GENE ANALYSIS FULL DUP DEL ANALYSIS	Genetic Counseling & Testing	Y				
81165	BRCA1 GENE ANALYSIS FULL SEQUENCE ANALYSIS	Genetic Counseling & Testing	Y				
81166	BRCA1 GENE ANALYSIS FULL DUP DEL ANALYSIS	Genetic Counseling & Testing	Y				
81167	BRCA2 GENE ANALYSIS FULL DUP DEL ANALYSIS	Genetic Counseling & Testing	Y				
81168	CCND1/IGH TRANSLOCATION ALYS MAJOR BP QUAL AND QUAN	Genetic Counseling & Testing	Y				
81171	AFF2 GENE ANALYSIS EVAL DETECT ABNORMAL ALLELES	Genetic Counseling & Testing	Y				
81172	AFF2 GENE ANALYSIS CHARACTERIZATION OF ALLELES	Genetic Counseling & Testing	Y				
81173	AR GENE ANALYSIS FULL GENE SEQUENCE	Genetic Counseling & Testing	Y				
81174	AR GENE ANALYSIS KNOWN FAMILIAL VARIANT	Genetic Counseling & Testing	Y				
81175	ASXL1 GENE ANALYSIS FULL GENE SEQUENCE	Genetic Counseling & Testing	Y				
81194	NTRK TRANSLOCATION ANALYSIS	Genetic Counseling & Testing	Y				
81201	APC GENE ANALYSIS FULL GENE SEQUENCE	Genetic Counseling & Testing	Y				
81212	BRCA1 BRCA 2 GEN ALYS 185DELAG 5385INSC 6174DELT	Genetic Counseling & Testing	Y				
81225	CYP2C19 GENE ANALYSIS COMMON VARIANTS	Genetic Counseling & Testing	Y				
81226	CYP2D6 GENE ANALYSIS COMMON VARIANTS	Genetic Counseling & Testing	Y				
81227	CYP2C9 GENE ANALYSIS COMMON VARIANTS	Genetic Counseling & Testing	Y				
81228	CYTOGENOM CONST MICROARRAY COPY NUMBER VARIANTS	Genetic Counseling & Testing	Y				
81229	CYTOGENOM CONST MICROARRAY COPY NUMBER AND SNP VAR	Genetic Counseling & Testing	Y				
81230	CYP3A4 GENE ANALYSIS COMMON VARIANTS	Genetic Counseling & Testing	Y				
81231	CYP3A5 GENE ANALYSIS COMMON VARIANTS	Genetic Counseling & Testing	Y				
81232	DYPD GENE ANALYSIS COMMON VARIANTS	Genetic Counseling & Testing	Y				
81236	EZH2 GENE ANALYSIS FULL GENE SEQUENCE	Genetic Counseling & Testing	Y				
81237	EZH2 GENE ANALYSIS COMMON VARIANTS	Genetic Counseling & Testing	Y				
81239	DMPK GENE ANALYSIS CHARACTERIZATION OF ALLELES	Genetic Counseling & Testing	Y				
81249	G6PD GENE ANALYSIS FULL GENE SEQUENCE	Genetic Counseling & Testing	Y				
81277	CYTOGENOMIC NEOPLASIA MICROARRAY ANALYSIS	Genetic Counseling & Testing	Y				
81292	MLH1 GENE ANALYSIS FULL SEQUENCE ANALYSIS	Genetic Counseling & Testing	Y				
81295	MSH2 GENE ANALYSIS FULL SEQUENCE ANALYSIS	Genetic Counseling & Testing	Y				
81298	MSH6 GENE ANALYSIS FULL SEQUENCE ANALYSIS	Genetic Counseling & Testing	Y				
81306	NUDT15 GENE ANALYSIS COMMON VARIANTS	Genetic Counseling & Testing	Y				
81307	PALB2 GENE ANALYSIS (FULL GENE SEQ)	Genetic Counseling & Testing	Y				
81309	PIK3CA GENE ANALYSIS TARGETED SEQUENCE ANALYSIS	Genetic Counseling & Testing	Y				
81314	PDGFRA GENE ANALYS TARGETED SEQUENCE ANALYS	Genetic Counseling & Testing	Y				
81317	PMS2 GENE ANALYSIS FULL SEQUENCE	Genetic Counseling & Testing	Y				
81321	PTEN GENE ANALYSIS FULL SEQUENCE ANALYSIS	Genetic Counseling & Testing	Y				
81333	TGFBI GENE ANALYSIS COMMON VARIANTS	Genetic Counseling & Testing	Y				
81351	TP53 GENE ANALYSIS FULL GENE SEQUENCE	Genetic Counseling & Testing	Y				
81404	MOLECULAR PATHOLOGY PROCEDURE LEVEL 5	Genetic Counseling & Testing	Y				
81405	MOLECULAR PATHOLOGY PROCEDURE LEVEL 6	Genetic Counseling & Testing	Y				
81406	MOLECULAR PATHOLOGY PROCEDURE LEVEL 7	Genetic Counseling & Testing	Y				
81407	MOLECULAR PATHOLOGY PROCEDURE LEVEL 8	Genetic Counseling & Testing	Y				
81408	MOLECULAR PATHOLOGY PROCEDURE LEVEL 9	Genetic Counseling & Testing	Y				
81410	AORTIC DYSFUNCTION DILATION GENOMIC SEQ ANALYSIS	Genetic Counseling & Testing	Y				
81411	AORTIC DYSFUNCTION DILATION DUP DEL ANALYSIS	Genetic Counseling & Testing	Y				
81412	ASHKENAZI JEWISH ASSOC DSRDRS GEN SEQ ANAL 9 GEN	Genetic Counseling & Testing	Y				
81413	CAR ION CHNNLPATH GENOMIC SEQ ALYS INC 10 GNS	Genetic Counseling & Testing	Y				
81414	CAR ION CHNNLPATH DUP DEL GN ALYS PANEL 2 GENES	Genetic Counseling & Testing	Y				
81415	EXOME SEQUENCE ANALYSIS	Genetic Counseling & Testing	Y				
81416	EXOME SEQUENCE ANALYSIS EACH COMPARATOR EXOME	Genetic Counseling & Testing	Y				
81418	DRG MTBLSM (EG, PHRMCGNOMCS) GNOMIC SQNC ANLYSS PANL, MUST INCLD TSTNG OF ATLEAST 6 GENES, NCLDNG CYP2C19, CYP2D6, ND CYP2D6 DPLCTN/DELETN ANLYSS	Genetic Counseling & Testing	Y				
81419	EPILEPSY GENOMIC SEQUENCE ANALYSIS PANEL	Genetic Counseling & Testing	Y				
81422	FETAL CHROMOSOMAL MICRODELTJ GENOMIC SEQ ANALYS	Genetic Counseling & Testing	Y				
81425	GENOME SEQUENCE ANALYSIS	Genetic Counseling & Testing	Y				
81426	GENOME SEQUENCE ANALYSIS EACH COMPARATOR GENOME	Genetic Counseling & Testing	Y				
81427	GENOME RE-EVALUATION OF PREC OBTAINED GENOME SEQ	Genetic Counseling & Testing	Y				
81430	HEARING LOSS GENOMIC SEQUENCE ANALYSIS 60 GENES	Genetic Counseling & Testing	Y				
81431	HEARING LOSS DUP DEL ANALYSIS	Genetic Counseling & Testing	Y				
81432	HEREDITARY BRST CA-RELATED GEN SEQ ANALYS 10 GEN	Genetic Counseling & Testing	Y				
81434	HEREDITARY RETINAL DSRDRS GEN SEQ ANALYS 15 GEN	Genetic Counseling & Testing	Y				
81435	HEREDITARY COLON CA DSRDRS GEN SEQ ANALYS 10 GEN	Genetic Counseling & Testing	Y				
81437	HEREDTRY NURONDCRN TUM DSRDRS GEN SEQ ANAL 6 GEN	Genetic Counseling & Testing	Y				
81439	HEREDITARY CARDIOMYOPATHY GEN SEQ ANALYS 5 GEN	Genetic Counseling & Testing	Y				
81440	NUCLEAR MITOCHONDRIAL 100 GENE GENOMIC SEQ	Genetic Counseling & Testing	Y				
81441	BMFS SEQUENCE ANALYSIS PANEL AT LEAST 30 GENES	Genetic Counseling & Testing	Y				
81443	GENETIC TESTING FOR SEVERE INHERITED CONDITIONS	Genetic Counseling & Testing	Y				
81445	GEN SEQ ANALYS SOLID ORGAN NEOPLASM 5-50 GENE	Genetic Counseling & Testing	Y				
81448	HEREDITARY PERIPHERAL NEUROPATHY GEN SEQ PNL	Genetic Counseling & Testing	Y				
81449	TRGTD GNMIC SQNC ANLYSS PANEL, SOLID ORGN NPLSM, 5-50 GENES (EG, ALK, BRAF, CDKN2A, EGFR, ERBB2, KIT, KRAS, MET, NRAS, PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET), INTRRGTION FOR SQNC VRNTS AND COPY NMBR VRNTS OR REARRNGMNTS, IF PRFRMD; RNA ANLYSS	Genetic Counseling & Testing	Y				
81450	GEN SEQ ANALYS HEMATOLYMPHOID NEO 5-50 GENE	Genetic Counseling & Testing	Y				
81451	TGSAP HEMATOLYMPHOID NEO/DO 5-50 RNA ANALYSIS	Genetic Counseling & Testing	Y				
81455	GEN SEQ ANALYS SOL ORG HEMTOLMPHOID NEO 51 OR GRT GEN	Genetic Counseling & Testing	Y				
81456	TGSAP SO/HEMATOLYMPHOID NEO/DO 51 OR LT RNA ANALYSIS	Genetic Counseling & Testing	Y				
81460	WHOLE MITOCHONDRIAL GENOME	Genetic Counseling & Testing	Y				
81465	WHOLE MITOCHONDRIAL GENOME ANALYSIS PANEL	Genetic Counseling & Testing	Y				
81470	X-LINKED INTELLECTUAL DBLT GENOMIC SEQ ANALYS	Genetic Counseling & Testing	Y				
81471	X-LINKED INTELLECTUAL DBLT DUP DEL GENE ANALYS	Genetic Counseling & Testing	Y				

81479	UNLISTED MOLECULAR PATHOLOGY PROCEDURE	Genetic Counseling & Testing	Y				
81493	COR ART DISEASE MRNA GENE EXPRESSION 23 GENES	Genetic Counseling & Testing	Y				
81503	ONCO (OVARIAN) BIOCHEMICAL ASSAY FIVE PROTEINS	Genetic Counseling & Testing	Y				
81504	ONCOLOGY TISSUE OF ORIGIN SIMILAR SCOR ALGORITHM	Genetic Counseling & Testing	Y				
81518	ONCOLOGY BREAST MRNA GENE EXPRESSION 11 GENES	Genetic Counseling & Testing	Y				
81519	ONCOLOGY BREAST MRNA GENE EXPRESSION 21 GENES	Genetic Counseling & Testing	Y				
81520	ONC BREAST MRNA GENE XPRSN PRFL HYBRD 58 GENES	Genetic Counseling & Testing	Y				
81521	ONC BREAST MRNA MICRORA GENE XPRSN PRFL 70 GENES	Genetic Counseling & Testing	Y				
81522	ONCOLOGY BREAST MRNA GENE XPRSN PRFL 12 GENES	Genetic Counseling & Testing	Y				
81523	ONC BRST MRNA NEXT GNRJ SEQ GEN XPRSN 70 CNT AND 31	Genetic Counseling & Testing	Y				
81525	ONCOLOGY COLON MRNA GENE EXPRESSION 12 GENES	Genetic Counseling & Testing	Y				
81529	ONC CUTAN MLNMA MRNA GENE XPRS PRFL 31 GENES ALG	Genetic Counseling & Testing	Y				
81535	ONCOLOGY GYNE LIVE TUM CELL CLTR AND CHEMO RESP 1ST	Genetic Counseling & Testing	Y				
81536	ONCOLOGY GYNE LIVE TUM CELL CLTR AND CHEMO RESP ADD	Genetic Counseling & Testing	Y				
81538	ONCOLOGY LUNG MS 8-PROTEIN SIGNATURE	Genetic Counseling & Testing	Y				
81540	ONCOLOGY TUM UNKNOWN ORIGIN MRNA 92 GENES	Genetic Counseling & Testing	Y				
81541	ONC PROSTATE MRNA GENE XPRSN PRFL RT-PCR 46 GENES	Genetic Counseling & Testing	Y				
81542	ONC PROSTATE MRNA MICRORA GENE XPRSN PRFL 22 GENES	Genetic Counseling & Testing	Y				
81546	ONC THYR MRNA 10,196 GENES FINE NDL ASPIRATE ALG	Genetic Counseling & Testing	Y				
81551	ONC PROSTATE PRMTR METHYLATION PRFL R-T PCR 3 GENES	Genetic Counseling & Testing	Y				
81552	ONC UVEAL MLNMA MRNA GENE XPRSN PRFL 15 GENES	Genetic Counseling & Testing	Y				
81554	PULM DS IPF MRNA 190 GENE TRANSBRONCHIAL BX ALG	Genetic Counseling & Testing	Y				
81595	CARDIOLOGY HRT TRNSPL MRNA GENE EXPRESS 20 GENES	Genetic Counseling & Testing	Y				
81599	UNLISTED MULTIANALYTE ASSAY ALGORITHMIC ANALYSIS	Genetic Counseling & Testing	Y				
84999	UNLISTED CHEMISTRY PROCEDURE	Genetic Counseling & Testing	Y				
0005U	ONCO PROSTATE GENE XPRS PRFL 3 GENE UR ALG RSK SCOR	Genetic Counseling & Testing	Y				
0006M	ONCOLOGY HEP MRNA 161 GENES RISK CLASSIFIER	Genetic Counseling & Testing	Y				
0007M	ONCOLOGY GASTRO 51 GENES NOMOGRAM DISEASE INDEX	Genetic Counseling & Testing	Y				
0009U	ONC BRST CA ERBB2 COPY NUMBER FISH AMP NONAMP	Genetic Counseling & Testing	Y				
0022U	TRGT GEN SEQ ALYS NONSM LNG NEO DNA AND RNA 23 GENES	Genetic Counseling & Testing	Y				
0037U	TRGT GEN SEQ ALYS SLD ORGN NEO DNA 324 GENES	Genetic Counseling & Testing	Y				
0070U	CYP2D6 GENE ANALYSIS COMMON AND SELECT RARE VRNTS	Genetic Counseling & Testing	Y				
0140U	NFCT DS FUNGAL PATHOGEN ID DNA 15 FUNGAL TARGETS	Genetic Counseling & Testing	Y				
0152U	NFCT DS BCT FNG PARASITE DNA VIR DETCJ OVER 1000 ORG	Genetic Counseling & Testing	Y				
0153U	ONC BREAST MRNA GENE EXPRESSION PRFL 101 GENES	Genetic Counseling & Testing	Y				
0154U	ONC UROTHELIAL CANCER RNA RT-PCR FGFR3 GENE ALYS	Genetic Counseling & Testing	Y				
0155U	ONC BRST CA DNA PIK3CA GENE ALYS BRST TUM TISS	Genetic Counseling & Testing	Y				
0172U	ONC SLD TUM ALYS BRCA1 BRCA2	Genetic Counseling & Testing	Y				
0173U	PSYC GEN ALYS PANEL 14 GENES	Genetic Counseling & Testing	Y				
0174U	OC SLD TUMOR 30 PRTN TRGT	Genetic Counseling & Testing	Y				
0175U	PSYC GEN ALYS PANEL 15 GENES	Genetic Counseling & Testing	Y				
0179U	ONC NONSM CLL LNG CA ALYS 23	Genetic Counseling & Testing	Y				
0184U	DO GNOTYP ART4 EXON 2	Genetic Counseling & Testing	Y				
0196U	LU GNOTYP BCAM EXON 3	Genetic Counseling & Testing	Y				
0209U	CYTOG CONST ALYS INTERROG	Genetic Counseling & Testing	Y				
0215U	RARE DS XOM DNA ALYS EA COMP	Genetic Counseling & Testing	Y				
0216U	NEURO INH ATAXIA DNA 12 COM	Genetic Counseling & Testing	Y				
0217U	NEURO INH ATAXIA DNA 51 GENE	Genetic Counseling & Testing	Y				
0218U	NEURO MUSC DYS DMD SEQ ALYS	Genetic Counseling & Testing	Y				
0239U	TRGT GEN SEQ ALYS SLD ORGN NEO CLL-FR DNA 311 PLUS	Genetic Counseling & Testing	Y				
0345U	PSYC GENOMIC ALYS PANEL VARIANT ALYS 15 GENES	Genetic Counseling & Testing	Y				
0387U	ONC MLNMA AMBRA1&LORICRIN IMHCHEM FFPE TISS	Genetic Counseling & Testing	Y				
0388U	ONC NONSM CLL LNG CA NXT GNRJ SEQ 37 CA RLTD GEN	Genetic Counseling & Testing	Y				
0389U	PED FEBRILE ILNES KAWASAKI DS IFI27&MCEP1 RNA	Genetic Counseling & Testing	Y				
0390U	OB PREECLAMPSIA KDR ENDOGLIN&RBP4 IA SRM ALG	Genetic Counseling & Testing	Y				
0391U	ONC SLD TUM DNA&RNA NXT GNJ SEQ FFPE TISS 437	Genetic Counseling & Testing	Y				
0392U	RX METAB GEN-RX IA VRNT ALYS 16 GENES CYP2D6	Genetic Counseling & Testing	Y				
0393U	NEURO PRKNSN CSF DETCJ MSFLD A-SYNCLN PRTN QUAL	Genetic Counseling & Testing	Y				
0394U	PFAS 16 PFAS COMPND LC MS/MS PLSM/SRM QUAN	Genetic Counseling & Testing	Y				
0395U	ONC LUNG MULTIOMICS PLASMA ALG MAL RISK LNG NDUL	Genetic Counseling & Testing	Y				
0398U	GI BARRETT ESOPH DNA MTHYLTN ALYS ALG DYSP/CA	Genetic Counseling & Testing	Y				
0399U	U NEURO CEREBRAL FOLATE DEFICIENCY SERUM QUAN	Genetic Counseling & Testing	Y				
0400U	OB XPND CAR SCR 145 GEN NXT GNRJ SEQ FRAG ALYS	Genetic Counseling & Testing	Y				
0401U	CRD C HRT DS 9 GEN 12 VRNTS TRGT VRNT GNOTYP ALG	Genetic Counseling & Testing	Y				
0402U	NFCT AGT STI MULT AMP PRB TQ VAG ENDOCRV/MALE UR	Genetic Counseling & Testing	Y				
0403U	ONC PRSTB MRNA GEN XPRSN PRFLG 18GENS 1-CATCH UR	Genetic Counseling & Testing	Y				
0404U	ONC BRST CA SEMIQ MEAS THYMIDINE KINASE ACTV IA	Genetic Counseling & Testing	Y				
0405U	ONC PNCRTC 59 MTHYLTN HAPLOTYPE BLOCK MRK PLSM	Genetic Counseling & Testing	Y				
0406U	ONC LUNG FLOW CYTOMETRY SPUTUM 5 MARKERS ALG	Genetic Counseling & Testing	Y				
0407U	NEPHROLOGY DIABETIC CKD MULT ECLIA PLASMA ALG	Genetic Counseling & Testing	Y				
0409U	ONC SLD TUM DNA 80&RNA 36 GEN NEXT GNRJ SEQ PLSM	Genetic Counseling & Testing	Y				
0410U	ONC PNCRTC DNA WHL GN SEQ 5- HYDROXYMETHYLCYTO SN	Genetic Counseling & Testing	Y				
0411U	PSYC GENOMIC ALYS PANEL VARIANT ALYS 15 GENES	Genetic Counseling & Testing	Y				
0412U	BETA AMYLOID AB42/40 IMPRCIP QUAN LCMS/MS ALG	Genetic Counseling & Testing	Y				
0413U	ONC HL NEO OPT GEN MAPG CPY NMBR ALTERATIONS DNA	Genetic Counseling & Testing	Y				
0414U	ONC LUNG AUGMNT ALG ALYS DGTZ WHOL SLD IMG 8 GEN	Genetic Counseling & Testing	Y				
0415U	CV DS ACS IA ALG BLOOD 5 YEAR DIL RISK SCORE ACS	Genetic Counseling & Testing	Y				
0417U	RARE DS WHL MITOCHDRL GEN SEQ ALYS 335 NUC GENES	Genetic Counseling & Testing	Y				
0418U	ONC BRST AUGMNT ALG ALYS DGTZ WHOL SLD IMG BREAT	Genetic Counseling & Testing	Y				
0419U	NEUROPSYCHIATRY GEN SEQ ALYS PNL VRNT ALY 13 GEN	Genetic Counseling & Testing	Y				
90281	IMMUNE GLOBULIN IG HUMAN IM USE	Healthcare Administered Drugs	Y				
90283	IMMUNE GLOBULIN IGIV HUMAN IV USE	Healthcare Administered Drugs	Y				
90284	IMMUNE GLOBULIN HUMAN SUBQ INFUSION 100 MG EA	Healthcare Administered Drugs	Y				
90291	CYTOMEGALOVIRUS IMMUNE GLOBULIN HUMAN IV	Healthcare Administered Drugs	Y				
90371	HEPATITIS B IMMUNE GLOBULIN HBIG HUMAN IM	Healthcare Administered Drugs	Y				
90378	RESPIRATORY SYNCYTIAL VIRUS IG IM 50 MG E	Healthcare Administered Drugs	Y				
A9596	GALLIUM GA -68GOZETOTIDE, DIAGNOSTIC, (ILLUCCIX), 1 MILLICURIE	Healthcare Administered Drugs	Y				
A9601	FLORTAUCIPIR -18INJECTION, DIAGNOSTIC, 1 MILLICURIE	Healthcare Administered Drugs	Y				
A9607	LUTETIUM LU 177 VIPIVOTIDE TETRAXETAN THER 1 MCI	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
B4187	OMEGAVEN, 10 G LIPIDS	Healthcare Administered Drugs	Y				
B4199	PARNTRAL NUT SOL; AMINO ACID and CARB GT 100 GMS PPAR	Healthcare Administered Drugs	Y				
C9047	INJECTION CAPLACIZUMAB-YHDP 1 MG	Healthcare Administered Drugs	Y				
C9145	INJ, APONVIE, 1 MG	Healthcare Administered Drugs	Y				
C9173	INJ, NYPOZI, 1 MCG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
C9257	INJECTION BEVACIZUMAB 0.25 MG	Healthcare Administered Drugs	Y		Bevacizumab when billed for intracular injection does not require a PA		
C9293	INJECTION GLUCARPIDASE 10 UNITS	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
C9399	UNCLASSIFIED DRUGS OR BIOLOGICALS	Healthcare Administered Drugs	Y				
C9488	INJECTION CONIVAPTAN HYDROCHLORIDE 1 MG	Healthcare Administered Drugs	Y				
J0121	INJECTION OMADACYCLINE 1 MG	Healthcare Administered Drugs	Y				
J0122	INJECTION, ERAVACYCLINE, 1 MG	Healthcare Administered Drugs	Y				
J0129	INJ ABATACEPT 10 MG USED MEDICARE ADM SUPV PHYS	Healthcare Administered Drugs	Y				
J0139	INJ, ADALIMUMAB, 1 MG	Healthcare Administered Drugs	Y				
J0172	INJECTION, ADUCANUMAB-AVWA, 2MG	Healthcare Administered Drugs	Y				
J0174	INJ, LECANEMAB-IRMB, 1 MG	Healthcare Administered Drugs	Y				
J0175	INJ, DONANEMAB-AZBT, 2 MG	Healthcare Administered Drugs	Y				
J0177	INJECTION, AFLIBERCEPT HD, 1 MG	Healthcare Administered Drugs	Y				
J0178	INJECTION AFLIBERCEPT 1 MG	Healthcare Administered Drugs	Y				
J0179	INJECTION, BROLUCIZUMAB-DBLL, 1MG	Healthcare Administered Drugs	Y				
J0180	INJECTION AGALSIDASE BETA 1 MG	Healthcare Administered Drugs	Y				
J0185	INJ., APREPITANT, 1MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J0202	INJECTION ALEMTUZUMAB 1 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J0207	INJECTION AMIFOSTINE 500 MG	Healthcare Administered Drugs	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J0208	INJECTION, SODIUM THIOSULFATE, 100 MG	Healthcare Administered Drugs	Y				
J0209	INJECTION, SODIUM THIOSULFATE (HOPE), 100 MG	Healthcare Administered Drugs	Y				
J0217	INJ, VELMANASE ALFA-TYCV, 1 MG	Healthcare Administered Drugs	Y				
J0218	INJECTION, OLIPUDASE ALFA-RPCP, 1 MG	Healthcare Administered Drugs	Y				
J0219	INJECTION, AVALGLUCOSIDASE ALFA-NGPT 4 MG	Healthcare Administered Drugs	Y				
J0221	INJECTION ALGLUCOSIDASE ALFA LUMIZYME 10 MG	Healthcare Administered Drugs	Y				
J0222	INJECTION PATISIRAN 0.1 MG	Healthcare Administered Drugs	Y				
J0223	INJECTION, GIVOSIRAN, 0.5 MG	Healthcare Administered Drugs	Y				
J0224	INJ, LUMASIRAN, 0.5 MG	Healthcare Administered Drugs	Y				
J0225	INJ, VUTRISIRAN, 1 MG	Healthcare Administered Drugs	Y				
J0248	INJ, REMDESIVIR, 1 MG	Healthcare Administered Drugs	Y				
J0256	INJECTION ALPHA 1-PROTASE INHIBITOR NOS 10 MG	Healthcare Administered Drugs	Y				
J0257	INJECTION ALPHA 1 PROTEINASE INHIBITOR 10 MG	Healthcare Administered Drugs	Y				
J0291	INJECTION PLAZOMICIN 5 MG	Healthcare Administered Drugs	Y				
J0349	INJECTION, REZAFUNGIN, 1 MG	Healthcare Administered Drugs	Y				
J0364	INJECTION APOMORPHINE HYDROCHLORIDE 1 MG	Healthcare Administered Drugs	Y				
J0480	INJECTION BASILIXIMAB 20 MG	Healthcare Administered Drugs	Y				
J0485	INJECTION BELATACEPT 1 MG	Healthcare Administered Drugs	Y				
J0490	INJECTION BELIMUMAB 10 MG	Healthcare Administered Drugs	Y				
J0491	INJECTION ANIFROLUMAB-FNIA 1 MG	Healthcare Administered Drugs	Y				
J0517	INJECTION BENRALIZUMAB 1 MG	Healthcare Administered Drugs	Y				
J0565	INJECTION BEZLOTOXUMAB 10 MG	Healthcare Administered Drugs	Y				
J0567	INJECTION CERLIPONASE ALFA 1 MG	Healthcare Administered Drugs	Y				
J0584	INJECTION BUROSUMAB-TWZA 1 MG	Healthcare Administered Drugs	Y				
J0585	BOTULINUM TOXIN TYPE A PER UNIT	Healthcare Administered Drugs	Y				
J0586	INJECTION ABOBOTULINUMTOXINA 5 UNITS	Healthcare Administered Drugs	Y				
J0587	INJECTION RIMABOTULINUMTOXINB 100 UNITS	Healthcare Administered Drugs	Y				
J0588	INJECTION INCOBOTULINUMTOXIN A 1 UNIT	Healthcare Administered Drugs	Y				
J0589	INJECTION, DAXIBOTULINUMTOXINA-LANM, 1 UNIT	Healthcare Administered Drugs	Y				
J0593	INJECTION, LANADELUMAB-FLYO 1 MG	Healthcare Administered Drugs	Y				
J0596	INJECTION C1 ESTERASE INHIBITOR RUCONEST 10 U	Healthcare Administered Drugs	Y				
J0597	INJ C-1 ESTERASE INHIB HUMN BERINERT 10 UNITS	Healthcare Administered Drugs	Y				
J0598	INJECTION C1 ESTERASE INHIBITOR CINRYZE 10 UNITS	Healthcare Administered Drugs	Y				
J0599	INJECTION C-1 ESTERASE INHIBITOR 10 UNITS	Healthcare Administered Drugs	Y				
J0601	SEVELAMER CARBONATE 20 MG	Healthcare Administered Drugs	NC		Services covered through pharmacy benefit.		
J0602	SEVELAMER CARBONATE PDR 20MG	Healthcare Administered Drugs	NC		Services covered through pharmacy benefit.		
J0603	SEVELAMER HYDROCHLORIDE 20MG	Healthcare Administered Drugs	NC		Services covered through pharmacy benefit.		
J0604	CINACALCET ORAL 1 MG	Healthcare Administered Drugs	Y				
J0605	SUCROFERRIC OXYHYDROXIDE 5MG	Healthcare Administered Drugs	NC		Services covered through pharmacy benefit.		
J0606	INJECTION ETELCALCETIDE 0.1 MG	Healthcare Administered Drugs	Y				
J0607	LANTHANUM CARBONATE ORAL 5MG	Healthcare Administered Drugs	NC		Services covered through pharmacy benefit.		
J0608	LANTHANUM CARBONATE PWDR 5MG	Healthcare Administered Drugs	NC		Services covered through pharmacy benefit.		
J0609	FERRIC CITRATE ORL 3 MG IRON	Healthcare Administered Drugs	NC		Services covered through pharmacy benefit.		
J0615	CALCIUM ACETATE, ORAL, 23 MG	Healthcare Administered Drugs	NC		Services covered through pharmacy benefit.		
J0630	CALCITONIN SALMON INJECTION	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J0638	INJECTION CANAKINUMAB 1 MG	Healthcare Administered Drugs	Y				
J0641	INJECTION LEVOLEUCOVORIN CALCIUM 0.5 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J0642	INJECTION LEVOLEUCOVORIN (KHAPZORY), 0.5 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J0695	INJECTION CEFTOLOZANE 50 MG AND TAZOBACTAM 25 MG	Healthcare Administered Drugs	Y				
J0699	INJECTION, CEFIDEROCOL, 10 MG	Healthcare Administered Drugs	Y				
J0712	INJECTION, CEFTAROLINE FOSAMIL, 10 MG	Healthcare Administered Drugs	Y				
J0714	INJECTION CEFTAZIDIME AND AVIBACTAM 0.5 G 0.125 G	Healthcare Administered Drugs	Y				
J0717	INJECTION CERTOLIZUMAB PEGOL 1 MG	Healthcare Administered Drugs	Y				
J0725	INJECTION CHORIONIC GONADOTROPIN-1000 USP UNITS	Healthcare Administered Drugs	Y				
J0739	INJECTION, CABOTEGRAVIR, 1 MG	Healthcare Administered Drugs	Y				
J0741	INJECTION, CABOTEGRAVIR AND RILPIVIRINE, 2 MG/3 MG	Healthcare Administered Drugs	Y				
J0775	INJ COLLAGENASE CLOSTRIDIUM HISTOLYTICUM 0.01 MG	Healthcare Administered Drugs	Y				
J0791	INJECTION, CRIZANLIZUMAB-TMCA, 5 MG	Healthcare Administered Drugs	Y				
J0801	INJECTION, CORTICOTROPIN (ACTHAR GEL), UP TO 40 UNITS	Healthcare Administered Drugs	Y				
J0802	INJECTION, CORTICOTROPIN (ANI), UP TO 40 UNITS	Healthcare Administered Drugs	Y				
J0850	INJECTION CYTOMEGALOVIRUS IMMUNE GLOB IV-VIAL	Healthcare Administered Drugs	Y				
J0870	INJ, IMETELSTAT, 1 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J0872	INJ, DAPTOMYCIN (XELLIA), UNREFRIGERATED, NOT THERAPEUTICALLY EQUIVALENT TO J0878 OR J0873, 1 MG	Healthcare Administered Drugs	Y				
J0873	INJ, DAPTOMYCIN (XELLIA) NOT THERAPEUTICALLY EQUIVALENT TO J0878, 1 MG	Healthcare Administered Drugs	Y				
J0874	INJECTION, DAPTOMYCIN (BAXTER), NOT THERAPEUTICALLY EQUIVALENT TO J0878, 1 MG	Healthcare Administered Drugs	Y				
J0875	INJECTION DALBAVANCIN 5MG	Healthcare Administered Drugs	Y				
J0877	INJ, DAPTOMYCIN (HOSPIRA)	Healthcare Administered Drugs	Y				
J0878	INJECTION DAPTOMYCIN 1 MG	Healthcare Administered Drugs	Y				
J0879	INJECTION DIFELIKEFALIN 0.1 MICROGRAM	Healthcare Administered Drugs	Y				
J0881	INJECTION DARBEPOETIN ALFA 1 MCG NON-ESRD USE	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J0885	INJECTION EPOETIN ALFA FOR NON-ESRD 1000 UNITS	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J0888	INJECTION EPOETIN BETA 1 MICROGRAM	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J0889	DAPRODUSTAT, ORAL, 1 MG, (FOR ESRD ON DIALYSIS)	Healthcare Administered Drugs	Y				
J0893	INJ, DECITABINE (SUN PHARMA)	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J0894	INJECTION DECITABINE 1 MG	Healthcare Administered Drugs	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J0896	INJECTION, LUPATERCEPT-AAMT, 0.25 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J0897	INJECTION DENOSUMAB 1 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J0901	VADADUSTAT, ORAL, 1 MG (FOR ESRD ON DIALYSIS)	Healthcare Administered Drugs	Y				
J0911	INSTILLATION, TAUROLIDINE 1.35 MG AND HEPARIN SODIUM 100 UNITS (CENTRAL VENOUS CATHETER LOCK FOR ESRD ON DIALYSIS)	Healthcare Administered Drugs	Y				
J1095	INJECTION DEXAMETHASONE 9PCT INTRAOCULAR 1 MCG	Healthcare Administered Drugs	Y				
J1096	DEXAMETHASONE LACRIMAL OPHTHALMIC INSERT 0.1 MG	Healthcare Administered Drugs	Y				
J1105	DEXMEDETOMIDINE, ORAL, 1 MCG	Healthcare Administered Drugs	Y				
J1190	INJECTION DEXRAZOXANE HYDROCHLORIDE PER 250 MG	Healthcare Administered Drugs	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J1202	MIGLUSTAT, ORAL, 65 MG	Healthcare Administered Drugs	Y				
J1203	INJECTION, CIPAGLUCOSIDASE ALFA-ATGA, 5 MG	Healthcare Administered Drugs	Y				
J1260	INJECTION DOLASETRON MESYLATE 10 MG	Healthcare Administered Drugs	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with		Y
J1290	INJECTION ECALLANTIDE 1 MG	Healthcare Administered Drugs	Y				
J1299	INJ, ECULIZUMAB, 2 MG	Healthcare Administered Drugs	Y				
J1301	INJECTION EDARAVONE 1 MG	Healthcare Administered Drugs	Y				
J1302	INJ SUTIMLIMAB-JOME 10 MG	Healthcare Administered Drugs	Y				
J1303	INJECTION RAVULIZUMAB-CWVZ 10 MG	Healthcare Administered Drugs	Y				
J1304	INJ, TOFERSEN, 1 MG	Healthcare Administered Drugs	Y				
J1305	INJECTION, EVINACUMAB-DGNB, 5 MG	Healthcare Administered Drugs	Y				
J1306	INJECTION, INCLISIRAN, MG	Healthcare Administered Drugs	Y				
J1307	INJ, CROVALIMAB-AKKZ, 10 MG	Healthcare Administered Drugs	Y				
J1322	INJECTION ELOSULFASE ALFA 1 MG	Healthcare Administered Drugs	Y				
J1323	INJECTION, ELRANATAMAB-BCMM, 1 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J1325	INJECTION EPOPROSTENOL 0.5 MG	Healthcare Administered Drugs	Y				
J1326	INJ ZOLBETUXIMAB, 1 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J1426	INJECTION, CASIMERSEN, 10 MG	Healthcare Administered Drugs	Y				
J1427	INJECTION, VILTOLARSEN, 10 MG	Healthcare Administered Drugs	Y				
J1428	INJECTION ETEPLIRSEN 10 MG	Healthcare Administered Drugs	Y				
J1429	INJECTION, GOLODIRSEN, 10 MG	Healthcare Administered Drugs	Y				
J1434	INJECTION, FOSAPREPITANT (FOCINVEZ), 1 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J1437	INJECTION, FERRIC DERISOMALTOSE, 10MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with		Y
J1438	INJECTION ETANERCEPT 25 MG	Healthcare Administered Drugs	Y				
J1439	INJECTION FERRIC CARBOXYMALTOSE 1 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with		Y
J1440	FECAL MICROBIOTA, LIVE - JSLM, 1 ML	Healthcare Administered Drugs	Y				
J1442	INJECTION FILGRASTIM EXCLUDES BIOSIMILARS 1 MIC	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J1447	INJECTION TBO-FILGRASTIM 1 MICROGRAM	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J1448	INJECTION, TRILACICLIB, 1 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J1449	INJECTION, EFLAPEGRASTIM-XNST, 0.1 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J1454	INJ FOSNETUPITANT 235 MG AND PALONOSETRON 0.25 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J1456	INJECTION, FOSAPREPITANT (TEVA), NOT THERAPEUTICALLY EQUIVALENT TO J1453, 1 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		
J1458	INJECTION GALSULFASE 1 MG	Healthcare Administered Drugs	Y				
J1459	INJ IMMUNE GLOBULIN IV NONLYOPHILIZED 500 MG (PRIVIGEN)	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J1460	INJECTION GAMMA GLOBULIN INTRAMUSCULAR 1 CC	Healthcare Administered Drugs	Y				
J1551	INJECTION, IMMUNE GLOBULIN (CUTAQUIG), 100 MG	Healthcare Administered Drugs	Y				
J1552	INJ, IMMUNE GLOBULIN (ALYGLO), 100 MG	Healthcare Administered Drugs	Y				
J1554	INJECTION, IMMUNE GLOBULIN (ASCENIV), 500 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J1555	INJECTION, IMMUNE GLOBULIN (CUVITRU), 100 MG	Healthcare Administered Drugs	Y				
J1556	INJECTION IMMUNE GLOBULIN BIVIGAM 500 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J1557	INJ IMMUNE GLOBULIN IV NONLYOPHILIZED 500 MG (GAMMAPLEX)	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J1558	INJECTION, IMMUNE GLOBULIN (XEMBIFY), 100 MG	Healthcare Administered Drugs	Y				
J1559	INJECTION IMMUNE GLOBULIN HIZENTRA 100 MG	Healthcare Administered Drugs	Y				
J1560	INJECTION GAMMA GLOB INTRAMUSCULAR OVER 10 CC	Healthcare Administered Drugs	Y				
J1561	INJECTION IMMUNE GLOBULIN NONLYOPHILIZED 500 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J1566	INJ IG IV LYPHILIZED NOT OTHERWISE SPEC 500 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J1568	INJ IG OCTOGAM IV NONLYOPHILIZED 500 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J1569	INJ IG GAMMAGARD LIQ IV NONLYOPHILIZED 500 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J1572	INJ IMMUNE GLOBULIN IV NONLYOPHILIZED 500 MG (FLEBOGAMMA/FLEBOGAMMA DIF)	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J1573	INJ HEP B IG HEPAGAM B INTRAVENOUS 0.5 ML	Healthcare Administered Drugs	Y				
J1575	INJ IMMUNE GLOBULIN HYALURONIDASE 100 MG IG	Healthcare Administered Drugs	Y				
J1576	INJECTION, IMMUNE GLOBULIN (PANZYGA), INTRAVENOUS, NONLYOPHILIZED (E.G., LIQUI	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J1595	INJECTION GLATIRAMER ACETATE 20 MG	Healthcare Administered Drugs	Y				
J1599	INJ IG IV NONLYOPHILIZED E.G. LIQUID NOS 500 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with		Y
J1602	INJECTION GOLIMUMAB 1 MG FOR INTRAVENOUS USE	Healthcare Administered Drugs	Y				
J1627	INJECTION GRANISETRON EXTENDED-RELEASE 0.1 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J1628	INJECTION GUSELKUMAB 1 MG	Healthcare Administered Drugs	Y				
J1632	INJECTION, BREXANOLONE, 1 MG	Healthcare Administered Drugs	Y				
J1640	INJECTION HEMIN 1 MG	Healthcare Administered Drugs	Y				
J1645	INJECTION DALTEPARIN SODIUM PER 2500 IU	Healthcare Administered Drugs	Y				
J1729	INJECTION HYDROXYPROGESTERONE CAPROATE NOS 10 MG	Healthcare Administered Drugs	Y				
J1740	INJECTION IBANDRONATE SODIUM 1 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J1743	INJECTION IDURSULFASE 1 MG	Healthcare Administered Drugs	Y				
J1744	INJECTION ICATIBANT 1 MG	Healthcare Administered Drugs	Y				
J1745	INJECTION INFLIXIMAB EXCLUDES BIOSIMILAR 10 MG	Healthcare Administered Drugs	Y				
J1746	INJECTION IBALIZUMAB-UIYK 10 MG	Healthcare Administered Drugs	Y				
J1747	INJECTION, SPESOLIMAB-SBZO, 1 M	Healthcare Administered Drugs	Y				
J1748	INJ, INFLIXIMAB-DYYB (ZYMFENTRA), 10 MG	Healthcare Administered Drugs	Y				
J1786	INJECTION IMIGLUCERASE 10 UNITS	Healthcare Administered Drugs	Y				
J1823	INJECTION, INEBILIZUMAB-CDON, 1 MG	Healthcare Administered Drugs	Y				
J1826	INJECTION INTERFERON BETA-1A 30 MCG	Healthcare Administered Drugs	Y				
J1830	INJECTION INTERFERON BETA-1B 0.25 MG	Healthcare Administered Drugs	Y				
J1833	INJECTION ISAVUCONAZONIUM 1 MG	Healthcare Administered Drugs	Y				

J1930	INJECTION LANREOTIDE 1 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J1931	INJECTION LARONIDASE 0.1 MG	Healthcare Administered Drugs	Y				
J1932	INJ LANREOTIDE CIPLA 1 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with		Y
J1941	INJECTION, FUROSEMIDE (FUROSCIX), 20 MG	Healthcare Administered Drugs	Y				
J1950	INJECTION LEUPROLIDE ACETATE PER 3.75 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J1951	INJECTION LEUPROLIDE AC FOR DEPOT SUSP 0.25 MG	Healthcare Administered Drugs	Y				
J1952	LEUPROLIDE INJECTABLE, CAMCEVI, 1MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J1954	INJ LUTRATE DEPOT 7.5 MG (CIPLA)	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J1961	INJECTION, LENACAPAVIR, 1 MG	Healthcare Administered Drugs	Y				
J2170	INJECTION MECASERMIN 1 MG	Healthcare Administered Drugs	Y				
J2182	INJECTION MEPOLIZUMAB 1 MG	Healthcare Administered Drugs	Y				
J2186	INJECTION MEROPENEM VABORBACTAM 10 MG 10 MG	Healthcare Administered Drugs	Y				
J2267	INJ, MIRIKIZUMAB-MRKZ, 1 MG	Healthcare Administered Drugs	Y				
J2277	INJECTION, MOTIXAFORTIDE, 0.25 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J2323	INJECTION NATALIZUMAB 1 MG	Healthcare Administered Drugs	Y				
J2327	INJ RISANKIZUMAB-RZAA 1 MG	Healthcare Administered Drugs	Y				
J2329	INJECTION, UBLITUXIMAB-XIIY, 1MG	Healthcare Administered Drugs	Y				
J2350	INJECTION OCRELIZUMAB 1 MG	Healthcare Administered Drugs	Y				
J2351	INJ, OCRELIZUMAB, 1 MG AND HYALURONIDASE-OCSQ	Healthcare Administered Drugs	Y				
J2353	INJ OCTREOTIDE DEPOT FORM IM INJ 1 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J2354	INJ OCTREOTIDE NON-DEPOT FORM SUBQ/IV INJ 25 MCG	Healthcare Administered Drugs	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with		Y
J2356	INJECTION, TEZEPELUMAB-EKKO, 1 MG	Healthcare Administered Drugs	Y				
J2357	INJECTION OMALIZUMAB 5 MG	Healthcare Administered Drugs	Y				
J2406	INJECTION, ORITAVANCIN (KIMYRSA), 10 MG	Healthcare Administered Drugs	Y				
J2407	INJECTION, ORITAVANCIN (ORBACTIV), 10 MG	Healthcare Administered Drugs	Y				
J2425	INJECTION PALIFERMIN 50 MICROGRAMS	Healthcare Administered Drugs	Y				
J2502	INJECTION PASIREOTIDE LONG ACTING 1 MG	Healthcare Administered Drugs	Y				
J2506	INJECTION, PEGFILGRASTIM, EXCLUDES BIOSIMILAR, 0.5 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J2507	INJECTION PEGLOTICASE 1 MG	Healthcare Administered Drugs	Y				
J2508	INJ, PEGUNIGALSIDASE ALFA-IWXJ, 1 MG	Healthcare Administered Drugs	Y				
J2562	INJECTION PLERIXAFOR 1 MG	Healthcare Administered Drugs	Y				
J2724	INJECTION PROTEIN C CONCENTRATE IV HUMAN 10 IU	Healthcare Administered Drugs	Y				
J2777	INJ FARICIMAB-SVOA 0.1 MG	Healthcare Administered Drugs	Y				
J2778	INJECTION RANIBIZUMAB 0.1 MG	Healthcare Administered Drugs	Y				
J2779	INJECTION, RANIBIZUMAB, VIA INTRAVITREAL IMPLANT (SUSVIMO), 0.1 MG	Healthcare Administered Drugs	Y				
J2781	INJECTION, PEGCETACOPLAN, INTRAVITREAL, 1 MG	Healthcare Administered Drugs	Y				
J2782	INJECTION, AVACINCAPTAD PEGOL, 0.1 MG	Healthcare Administered Drugs	Y				
J2783	INJECTION RASBURICASE 0.5 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J2786	INJECTION RESLIZUMAB 1 MG	Healthcare Administered Drugs	Y				
J2787	RIBOFLAVIN 5'-PHOSPHATE OPHTHALMIC SOL TO 3 ML	Healthcare Administered Drugs	Y				
J2793	INJECTION RILONACEPT 1 MG	Healthcare Administered Drugs	Y				
J2802	INJ, ROMIPLOSTIM, 1 MICROGRAM	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J2820	INJECTION SARGRAMOSTIM 50 MCG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J2840	INJECTION SEBELIPASE ALFA 1 MG	Healthcare Administered Drugs	Y				
J2860	INJECTION SILTUXIMAB 10 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J2941	INJECTION SOMATROPIN 1 MG	Healthcare Administered Drugs	Y				
J2998	INJECTION, PLASMINOGEN, HUMAN-TVMH, 1 MG	Healthcare Administered Drugs	Y				
J3031	INJECTION FREMANEZUMAB-VFRM 1 MG	Healthcare Administered Drugs	Y				
J3032	INJECTION, EPTINEZUMAB-JJMR, 1MG	Healthcare Administered Drugs	Y				
J3055	INJECTION, TALQUETAMAB-TGVS, 0.25 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J3060	INJECTION TALIGLUCERASE ALFA 10 UNITS	Healthcare Administered Drugs	Y				
J3090	INJECTION TEDIZOLID PHOSPHATE 1 MG	Healthcare Administered Drugs	Y				
J3095	INJECTION TELAVANCIN 10 MG	Healthcare Administered Drugs	Y				
J3110	INJECTION TERIPARATIDE 10 MCG	Healthcare Administered Drugs	Y				
J3111	INJECTION, ROMOSOZUMAB-AQQG, 1 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J3145	INJECTION TESTOSTERONE UNDECANOATE 1 MG	Healthcare Administered Drugs	Y				
J3241	INJECTION, TEPROTUMUMAB-TRBW, 10MG	Healthcare Administered Drugs	Y				
J3245	INJECTION TILDRAKIZUMAB 1 MG	Healthcare Administered Drugs	Y				
J3247	INJ, SECUKINUMAB, INTRAVENOUS, 1 MG	Healthcare Administered Drugs	Y				
J3262	INJECTION TOCILIZUMAB 1 MG	Healthcare Administered Drugs	Y				
J3263	INJ, TORIPALIMAB-TPZI, 1 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J3285	INJECTION TREPROSTINIL 1 MG	Healthcare Administered Drugs	Y				
J3299	INJECTION TRIAMCINOLONE ACETONIDE XIPERE 1 MG	Healthcare Administered Drugs	Y				
J3304	INJECT TRIAMCINOLONE ACETONIDE PF ER MS F 1 MG	Healthcare Administered Drugs	Y				
J3315	INJECTION TRIPTORELIN PAMOATE 3.75 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J3316	INJECTION TRIPTORELIN EXTENDED-RELEASE 3.75 MG	Healthcare Administered Drugs	Y				
J3357	USTEKINUMAB FOR SUBCUTANEOUS INJECTION 1 MG	Healthcare Administered Drugs	Y				
J3358	USTEKINUMAB FOR INTRAVENOUS INJECTION 1 MG	Healthcare Administered Drugs	Y				
J3380	INJECTION VEDOLIZUMAB 1 MG	Healthcare Administered Drugs	Y				
J3385	INJECTION VELAGLUCERASE ALFA 100 UNITS	Healthcare Administered Drugs	Y				
J3396	INJECTION VERTEPORFIN 0.1 MG	Healthcare Administered Drugs	Y				
J3397	INJECTION VESTRONIDASE ALFA-VJBK 1 MG	Healthcare Administered Drugs	Y				
J3490	UNCLASSIFIED DRUGS	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis, direct outpatient requests for drugs within Evolent scope to Evolent. For Pediatrics, inpatient, non-oncology requests, or drugs out of Evolent scope; direct request to the healthplan.		Y
J3590	UNCLASSIFIED BIOLOGICS	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis, direct outpatient requests for drugs within Evolent scope to Evolent. For Pediatrics, inpatient, non-oncology requests, or drugs out of Evolent scope; direct request to the healthplan.		Y
J3591	UNCLASS RX BIOLOGICAL USED FOR ESRD ON DIALYSIS	Healthcare Administered Drugs	Y				
J7168	PRT COMPLEX CONC KCENTRA PER IU FIX ACT	Healthcare Administered Drugs	Y				
J7170	INJECTION EMICIZUMAB-KXWH 0.5 MG	Healthcare Administered Drugs	Y				
J7171	INJ, ADAMTS13, RECOMBINANT-KRHN, 10 IU	Healthcare Administered Drugs	Y				
J7172	INJ MARSTACIMAB, 0.5 MG	Healthcare Administered Drugs	Y				
J7175	INJECTION FACTOR X 1 I.U.	Healthcare Administered Drugs	Y				
J7177	INJECTION HUMAN FIBRINOGEN CONCENTRATE 1 MG	Healthcare Administered Drugs	Y				
J7178	INJECTION HUMAN FIBRINOGEN CONC NOS 1 MG	Healthcare Administered Drugs	Y				
J7179	INJECTION VON WILLEBRAND FACTOR 1 I.U. VWF:RCO	Healthcare Administered Drugs	Y				
J7180	INJECTION FACTOR XIII 1 I.U.	Healthcare Administered Drugs	Y				
J7181	INJECTION FACTOR XIII A-SUBUNIT PER IU	Healthcare Administered Drugs	Y				
J7182	INJECTION FACTOR VIII PER IU (ANTIHEMOPHILIC FACTOR, RECOMBINANT), (NOVOEIGHT)	Healthcare Administered Drugs	Y				
J7183	INJ VON WILLEBRAND FACTR COMPLEX WILATE 1 IU:RCO	Healthcare Administered Drugs	Y				
J7185	INJECTION FACTOR VIII PER IU (ANTIHEMOPHILIC FACTOR, RECOMBINANT) (XYNTHA)	Healthcare Administered Drugs	Y				
J7186	INJ AHF VWF CMPLX PER FACTOR VIII IU	Healthcare Administered Drugs	Y				
J7187	INJ VONWILLEBRND FACTOR CMPLX HUMN RISTOCETIN IU	Healthcare Administered Drugs	Y				
J7188	INJECTION FACTOR VIII PER I.U.	Healthcare Administered Drugs	Y				
J7189	FACTOR VIIA ANTIHEMOPHILIC FCT NOVOSEVEN RT1 MCG	Healthcare Administered Drugs	Y				
J7190	FACTOR VIII ANTIHEMOPHILIC FACTOR HUMAN PER IU	Healthcare Administered Drugs	Y				
J7191	FACTOR VIII ANTIHEMOPHILIC FACTOR PROCINE PER IU	Healthcare Administered Drugs	Y				
J7192	FACTOR VIII PER IU NOT OTHERWISE SPECIFIED	Healthcare Administered Drugs	Y				
J7193	FACTOR IX AHF PURIFIED NON-RECOMBINANT PER IU	Healthcare Administered Drugs	Y				
J7194	FACTOR IX COMPLEX PER IU	Healthcare Administered Drugs	Y				
J7195	INJ FACTOR IX PER IU NOT OTHERWISE SPECIFIED	Healthcare Administered Drugs	Y				
J7196	INJECTION ANTITHROMBIN RECOMBINANT 50 I.U.	Healthcare Administered Drugs	Y				
J7197	ANTITHROMBIN III PER IU	Healthcare Administered Drugs	Y				
J7198	ANTI-INHIBITOR PER IU	Healthcare Administered Drugs	Y				
J7199	HEMOPHILIA CLOTTING FACTOR NOC	Healthcare Administered Drugs	Y				
J7200	INJECTION FACTOR IX RIXUBIS PER IU	Healthcare Administered Drugs	Y				
J7201	INJECTION FAC IX FC FUS PROTEIN ALPROLIX 1 I.U.	Healthcare Administered Drugs	Y				
J7202	INJECTION FAC IX ALBUMIN FUS PRT IDELVION 1 I.U.	Healthcare Administered Drugs	Y				
J7203	INJECTION FACTOR IX GLYCOPEGYLATED 1 IU	Healthcare Administered Drugs	Y				
J7204	INJ FACTR VIII ANTIHEM FAC GLYCOPEGYLATD-EXEI P-IU	Healthcare Administered Drugs	Y				
J7205	INJECTION FACTOR VIII FC FUSION PROTEIN PER IU	Healthcare Administered Drugs	Y				
J7207	INJECTION FACTOR VIII PEGYLATED 1 I.U.	Healthcare Administered Drugs	Y				
J7208	INJECTION FACTOR VIII PEGYLATED-AUCL 1 IU	Healthcare Administered Drugs	Y				
J7209	INJECTION FACTOR VIII 1 I.U.	Healthcare Administered Drugs	Y				
J7210	INJECTION FACTOR VIII AFSTYLA 1 I.U.	Healthcare Administered Drugs	Y				
J7211	INJECTION FACTOR VIII KOVALTRY 1 I.U.	Healthcare Administered Drugs	Y				
J7212	FCTR VIIA (ANTIHEMOPHILIC F FACTOR, RECOMBINANT)- JNCW (SEVENFACT), 1 MCG	Healthcare Administered Drugs	Y				
J7213	INJECTION, COAGULATION FACTOR IX (RECOMBINANT), IXINITY, 1 I.U.	Healthcare Administered Drugs	Y				
J7214	INJECTION, FACTOR VIII/VON WILLEBRAND FACTOR COMPLEX, RECOMBINANT (ALTUVIIIO), PER FACTOR VIII I.U."	Healthcare Administered Drugs	Y				
J7308	AMINOLEVULINIC ACID HCL TOP ADMN 20PCT 1 U DOSE	Healthcare Administered Drugs	Y				
J7311	FLUOCINOLONE ACETONIDE INTRAVITREAL IMPLANT	Healthcare Administered Drugs	Y				
J7312	INJECTION DEXAMETHASONE INTRAVITREAL IMPL 0.1 MG	Healthcare Administered Drugs	Y				
J7313	INJECTION FA INTRAVITREAL IMPLANT (LLUVIEN) 0.01 MG	Healthcare Administered Drugs	Y				
J7314	INJECTION FA INTRAVITREAL IMPLANT (YUTIQ), 0.01 MG	Healthcare Administered Drugs	Y				
J7318	HYALURONAN DERIVATIVE DUROLANE FOR IA INJ 1 MG	Healthcare Administered Drugs	Y				
J7320	HYALURONAN DERIVITIVE GENVISC 850 IA INJ 1 MG	Healthcare Administered Drugs	Y				
J7321	HYALURONAN/DERIV HYALGAN/SUPARTZ IA INJ PER DOSE	Healthcare Administered Drugs	Y				
J7322	HYALURONAN DERIVATIVE HYMOVIS IA INJ 1 MG	Healthcare Administered Drugs	Y				
J7323	HYALURONAN DERIVATIVE EUFLEXXA IA INJ PER DOSE	Healthcare Administered Drugs	Y				
J7324	HYALURONAN DERIV ORTHOVISC IA INJ PER DOSE	Healthcare Administered Drugs	Y				
J7325	HYALURONAN DERIV SYNVISC SYNVISC-ONE IA INJ 1 MG	Healthcare Administered Drugs	Y				
J7326	HYALURONAN DERIV GEL-ONE INTRA-ARTIC INJ PER DOS	Healthcare Administered Drugs	Y				
J7327	HYALURONAN DERIVATIVE MONOVISC IA INJ PER DOSE	Healthcare Administered Drugs	Y				
J7328	HYALURONAN DERIVATIVE GELSYN-3 FOR IA INJ 0.1 MG	Healthcare Administered Drugs	Y				
J7329	HYALURONAN DERIVATIVE TRIVISC FOR IA INJ 1 MG	Healthcare Administered Drugs	Y				
J7331	HYALURONAN/DERIVATIVE SYNOJOYNT IA INJ 1 MG	Healthcare Administered Drugs	Y				
J7332	HYALURONAN/DERIVATIVE TRILURON IA INJ 1 MG	Healthcare Administered Drugs	Y				
J7336	CAPSAICIN 8% PATCH, PER SQ CENTIMETER	Healthcare Administered Drugs	Y				
J7351	INJECTION BIMATOPROST INTRACAMERAL IMPLANT 1 MCG	Healthcare Administered Drugs	Y				
J7352	AFAMELANOTIDE IMPLANT, 1 MG	Healthcare Administered Drugs	Y				
J7353	ANACAULASE-BCDB, 8.8% GEL, 1 GRAM	Healthcare Administered Drugs	Y				
J7354	CANTHARIDIN FOR TOPICAL ADMINISTRATION, 0.7%, SINGLE UNIT DOSE APPLICATOR (3.2 MG)	Healthcare Administered Drugs	Y				
J7355	INJ, TRAVOPROST, INTRACAMERAL IMPLANT, 1 MICROGRAM	Healthcare Administered Drugs	Y				
J7356	INJ, FOSCARBIDOPA 0.25 MG/FOSLEVODOPA 5 MG	Healthcare Administered Drugs	Y				
J7402	MOMETASONE FUROATE SINUS IMPLANT SINUVA 10 MCG	Healthcare Administered Drugs	Y				
J7504	LYMPHCYT IMMUN GLOB EQUINE PARENTERAL 250 MG	Healthcare Administered Drugs	Y				
J7511	LYMPHCYT IMMUN GLOB RABBIT PARENTERAL 25 MG	Healthcare Administered Drugs	Y				
J7601	ENSIFENTRINE, INHALATION SUSPENSION, FDA APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 3 MG	Healthcare Administered Drugs	Y				
J7639	DORNASE ALFA INHAL SOL NONCOMP UNIT DOSE PER MG	Healthcare Administered Drugs	Y				
J7677	REVEFENACIN INHAL SOL NONCOMPND ADM DME 1 MCG	Healthcare Administered Drugs	Y				
J7682	TOBRAMYCIN INHAL NON-COMP UNIT DOSE PER 300 MG	Healthcare Administered Drugs	Y				
J7686	TREPROSTINIL INHAL SOLUTION UNIT DOSE 1.74 MG	Healthcare Administered Drugs	Y				
J7999	COMPOUNDED DRUG NOT OTHERWISE CLASSIFIED	Healthcare Administered Drugs	Y		Bevacizumab when billed for intraocular injection does not require a PA		
J8499	PRESCRIPTION DRUG ORAL NONCHEMOTHERAPEUTIC NOS	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis, direct outpatient requests for drugs within Evolent scope to Evolent. For Pediatrics, inpatient, non-oncology requests, or drugs out of Evolent scope; direct request to the healthplan.		Y
J8655	NETUPITANT 300 MG AND PALONOSETRON 0.5 MG ORAL	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J8670	ROLAPITANT ORAL 1 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J8999	PRESCRIPTION DRUG ORAL CHEMOTHERAPEUTIC NOS	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis, direct outpatient requests for drugs within Evolent scope to Evolent. For Pediatrics, inpatient, non-oncology requests, or drugs out of Evolent scope; direct request to the healthplan.		Y
J9000	INJECTION DOXORUBICIN HCL 10 MG	Healthcare Administered Drugs	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9015	INJECTION ALDESLEUKIN PER SINGLE USE VIAL	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9017	INJECTION ARSENIC TRIOXIDE 1 MG	Healthcare Administered Drugs	~	Y~	KY: If requesting this drug for delivery by a pharmacy, please visit kyportal.medimpact.com for authorization information. This drug is reviewed by MedImpact when requested under the Pharmacy Benefit. ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non-cancer diagnosis or inpatient, direct request to the healthplan. Pediatric members do not require PA for outpatient.		Y/MedImpact
J9019	INJECTION ASPARAGINASE ERWINAZE 1000 IU	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9020	INJECTION ASPARAGINASE 10000 UNITS	Healthcare Administered Drugs	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9021	INJECTION, ASPARAGINASE, RECOMBINANT, (RYLAZE), 0.1MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9022	INJECTION ATEZOLIZUMAB 10 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9023	INJECTION AVELUMAB 10 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9024	INJ, ATEZOLIZUMAB, 5 MG AND HYALURONIDASE-TQJS	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9025	INJECTION AZACITIDINE 1 MG	Healthcare Administered Drugs	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9026	INJ, TARLATAMAB-DLLE, 1 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9027	INJECTION CLOFARABINE 1 MG	Healthcare Administered Drugs	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9028	INJ, NOGAPENDEKIN ALFA INBAKICEPT-PMLN, FOR INTRAVESICAL USE, 1 MICROGRAM	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9030	BCG LIVE INTRAVESICAL INSTILLATION 1 MG	Healthcare Administered Drugs	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9032	INJECTION BELINOSTAT 10 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9033	INJECTION BENDAMUSTINE HCL TREANDA 1 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9034	INJECTION BENDAMUSTINE HCL BENDEKA 1 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9035	INJECTION BEVACIZUMAB 10 MG	Healthcare Administered Drugs	Y	Y~	Bevacizumab when billed for intraocular injection does not require a PA. ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9036	INJECTION BENDAMUSTINE HYDROCHLORIDE 1 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9038	INJ, AXATILIMAB-CSFR, 0.1 MG	Healthcare Administered Drugs	Y				
J9039	INJECTION BLINATUMOMAB 1 MICROGRAM	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9040	INJECTION BLEOMYCIN SULFATE 15 UNITS	Healthcare Administered Drugs	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9041	INJECTION BORTEZOMIB 0.1 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9042	INJECTION BRENTUXIMAB VEDOTIN 1 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9043	INJECTION CABAZITAXEL 1 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9045	INJECTION CARBOPLATIN 50 MG	Healthcare Administered Drugs	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9046	INJ, BORTEZOMIB, DR. REDDY'S	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9047	INJECTION CARFILZOMIB 1 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9048	INJ, BORTEZOMIB FRESENIUSKAB	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with		Y
J9049	INJ, BORTEZOMIB, HOSPIRA	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9050	INJECTION CARMUSTINE 100 MG	Healthcare Administered Drugs	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9051	INJECTION, BORTEZOMIB (MAIA), NOT THERAPEUTICALLY EQUIVALENT TO J9041, 0.1 MG	Healthcare Administered Drugs	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9052	INJ, CARMUSTINE (ACCORD)	Healthcare Administered Drugs	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y

J9054	INJ, BORTEZOMIB (BORUZU), 0.1 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9055	INJECTION CETUXIMAB 10 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9056	INJECTION, BENDAMUSTINE HYDROCHLORIDE (VIVIMUSTA), 1 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9057	INJECTION COPANLISIB 1 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with		Y
J9060	INJECTION CISPLATIN POWDER OR SOLUTION 10 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9061	INJECTION, AMIVANTAMAB-VMJW, 2MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9063	INJECTION, MIRVETUXIMAB SORAVTANSINE-GYNX, 1 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9064	INJECTION, CABAZITAXEL (SANDOZ), NOT THERAPEUTICALLY EQUIVALENT TO J9043, 1 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9065	INJECTION CLADRIBINE PER 1 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9071	INJECTION CYCLOPHOSPHAMIDE AUROMEDICS 5 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9072	INJ, CYCLOPHOSPHAMIDE, (DR. REDDY'S), 5 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9073	INJECTION, CYCLOPHOSPHAMIDE (INGENUS), 5 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9074	INJECTION, CYCLOPHOSPHAMIDE (SANDOZ), 5 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9075	INJECTION, CYCLOPHOSPHAMIDE, NOT OTHERWISE SPECIFIED, 5MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9076	INJ, CYCLOPHOSPHAMIDE (BAXTER) 5MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9100	INJECTION CYTARABINE 100 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9118	INJ. CALASPARGASE PEGOL-MKNL	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9119	INJECTION CEMIPLIMAB-RWLC 1 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9120	INJECTION DACTINOMYCIN 0.5 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9130	DACARBAZINE 100 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9144	INJECTION, DARATUMUMAB, 10 MG AND HYALURONIDASE-FIHJ	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9145	INJECTION DARATUMUMAB 10 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9150	INJECTION DAUNORUBICIN 10 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9153	INJECTION LIPOSOMAL 1 MG DNR AND 2.27 MG CA	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9155	INJECTION DEGARELIX 1 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9161	INJ, DENILEUKIN DIFTITOX-CXDL, 1 MCG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9171	INJECTION DOCETAXEL 1 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9172	DOCETAXEL (INGENUS), 1 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9173	INJECTION DURVALUMAB 10 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9174	INJ, DOCETAXEL (BEIZRAY), 1 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9176	INJECTION ELOTUZUMAB 1 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9177	INJECTION, ENFORTUMAB VEDOTIN-EJFV, 0.25 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9178	INJECTION EPIRUBICIN HCL 2 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9179	INJECTION ERIBULIN MESYLATE 0.1 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9181	INJECTION ETOPOSIDE 10 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9185	INJECTION FLUDARABINE PHOSPHATE 50 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9190	INJECTION FLUOROURACIL 500 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9196	INJECTION, GEMCITABINE HYDROCHLORIDE (ACCORD), NOT THERAPEUTICALLY EQUIVALENT TO J9201, 200 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9198	INJECTION, GEMCITABINE HYDROCHLORIDE (INFUGEM), 100 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9200	INJECTION FLOXURIDINE 500 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9201	INJECTION GEMCITABINE HCL NOS 200 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9202	GOSERELIN ACETATE IMPLANT PER 3.6 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient except for SC. For SC, submit request to the healthplan.		Y
J9203	INJECTION GEMTUZUMAB OZOGAMICIN 0.1 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9204	INJECTION MOGAMULIZUMAB-KPKC 1 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9205	INJECTION IRINOTECAN LIPOSOME 1 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9206	INJECTION IRINOTECAN 20 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient except for WA. WA pediatrics direct request to the healthplan.		Y
J9207	INJECTION IXABEPILONE 1 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9208	INJECTION IFOSFAMIDE 1 G	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9209	INJECTION MESNA 200 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9210	INJECTION EMAPALUMAB-LZSG 1 MG	Healthcare Administered Drugs	Y				
J9211	INJECTION IDARUBICIN HCL 5 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9214	INJECTION INTERFERON ALFA-2B RECOMBINANT 1 M U	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9215	INJECTION INTERFERON ALFA-N3 250,000 IU	Healthcare Administered Drugs	Y				
J9216	INJECTION INTERFERON GAMMA-1B 3 MILLION UNITS	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9217	LEUPROLIDE ACETATE 7.5 MG	Healthcare Administered Drugs	~	Y*	KY: If requesting this drug for delivery by a pharmacy, please visit kyportal.medimpact.com for authorization information. This drug is reviewed by MedImpact when requested under the Pharmacy Benefit. *Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the healthplan. Pediatric members do not require PA for outpatient except for MS, SC. For MS, SC; submit request to the healthplan.		Y/MedImpact
J9218	LEUPROLIDE ACETATE PER 1 MG	Healthcare Administered Drugs	Y	Y*	One J code unit allowed per calendar year without PA. All units in excess of one unit/year require PA. *Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9223	INJECTION, LURBINECTEDIN, 0.1 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9225	HISTRELIN IMPLANT VANTAS 50 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9226	HISTRELIN IMPLANT SUPPRELIN LA 50 MG	Healthcare Administered Drugs	Y				
J9227	INJECTION, ISATUXIMAB-IRFC, 10 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9228	INJECTION IPILIMUMAB 1 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9229	INJECTION INOTUZUMAB OZOGAMICIN 0.1 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9230	INJECTION MECHLORETHAMINE HCL 10 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9245	INJECTION MELPHALAN HCl NOS 50 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9246	INJECTION MELPHALAN EVOMELA 1 MG	Healthcare Administered Drugs	Y				
J9248	INJECTION, MELPHALAN (HEPZATO), 1 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9249	INJECTION MELPHALAN APOTEX 1 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9255	INJ, METHOTREXATE (ACCORD)	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9260	INJECTION METHOTREXATE SODIUM 50 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9261	INJECTION NELARABINE 50 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9262	INJECTION OMACETAXINE MEPESUCCINATE 0.01 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9263	INJECTION OXALIPLATIN 0.5 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9264	INJECTION PACLITAXEL PROTEINBOUND PARTICLES 1 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9266	INJECTION PEGASPARGASE PER SINGLE DOSE VIAL	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9267	INJECTION PACLITAXEL 1 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with		Y
J9268	INJECTION PENTOSTATIN 10 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9269	INJECTION TAGRAXOFUSP-ERZS 10 MCG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9271	INJECTION PEMBROLIZUMAB 1 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9272	INJECTION, DOSTARLIMAB-GXLY,10MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9273	INJECTION, TISOTUMAB VEDOTIN-TFTV, 1 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9274	INJ TEBENTAFUSP-TEBN 1 MCG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9275	INJ, COSIBELIMAB-IPDL, 2 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9276	INJ ZANIDATAMAB, 2 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9280	INJECTION MITOMYCIN 5 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9281	MITOMYCIN PYELOCALYCEAL INSTILLATION, 1 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9285	INJECTION OLARATUMAB 10 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9286	INJ, GLOFITAMAB-GXBM, 2.5 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9289	INJ, NIVOLUMAB, 2 MG AND HYALURONIDASENVHY	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9292	INJ, PEMETREXED (AVYXA), NOT THERAPEUTICALLY EQUIVALENT TO J9305, 10 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9293	INJECTION MITOXANTRONE HCL PER 5 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9294	INJECTION, PEMETREXED (HOSPIRA) NOT THERAPEUTICALLY EQUIVALENT TO J9305, 10 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9295	INJECTION NECITUMUMAB 1 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9296	INJECTION, PEMETREXED (ACCORD) NOT THERAPEUTICALLY EQUIVALENT TO J9305, 10 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9297	INJECTION, PEMETREXED (SANDOZ), NOT THERAPEUTICALLY EQUIVALENT TO J9305, 10 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9298	INJ NIVOLUMAB AND RELATLIMAB-RMBW 3 MG/1 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9299	INJECTION NIVOLUMAB 1 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9301	INJECTION OBINUTUZUMAB 10 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9302	INJECTION OFATUMUMAB 10 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9303	INJECTION PANITUMUMAB 10 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9304	INJECTION PEMETREXED (PEMFEXY) 10 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9305	INJECTION PEMETREXED 10 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9306	INJECTION PERTUZUMAB 1 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9307	INJECTION PRALATREXATE 1 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9308	INJECTION RAMUCIRUMAB 5 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9309	INJECTION, POLATUZUMAB VEDOTIN-PIIQ, 1 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9311	INJECTION RITUXIMAB 10 MG AND HYALURONIDASE	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9312	INJECTION RITUXIMAB 10 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9313	INJECTION MOXETUMOMAB PASUDOTOX-TDFK 0.01 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9314	INJ PEMETREXED (TEVA) 10MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		
J9316	INJECTION, PERTUZUMAB, TRASTUZUMAB, AND HYALURONIDASE-ZZXF, PER 10 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9317	INJECTION, SACITUZUMAB GOVITECAN-HZIY, 2.5 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9318	INJECTION, ROMIDEPSIN, NONLYOPHILIZED, 0.1 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9319	INJECTION, ROMIDEPSIN, LYOPHILIZED, 0.1 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9320	INJECTION STREPTOZOCIN 1 G	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9321	INJECTION EPCORITAMAB-BYSP 0.16 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9322	INJECTION, PEMETREXED (BLUEPOINT) NOT THERAPEUTICALLY EQUIVALENT TO J9305, 10	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9323	INJECTION, PEMETREXED DITROMETHAMINE, 10 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9324	INJ, PEMETREXED (PEMRYDI RTU), 10 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9325	INJ TALIMOGENE LAHERPAREPVEC PER 1 M PLAQUE F U	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9328	INJECTION TEMOZOLOMIDE 1 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9329	INJ, TISLELIZUMAB-JSGR, 1 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9330	INJECTION TEMSIROLIMUS 1 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9331	INJECTION, SIROLIMUS PROTEIN-BOUND PARTICLES, 1 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9332	INJECTION, EFGARTIGIMOD ALFA-FCAB, 2 MG	Healthcare Administered Drugs	Y				
J9333	INJ, ROZANOLIXIZUMAB-NOLI, 1 MG	Healthcare Administered Drugs	Y				
J9334	INJ, EFGARTIGIMOD ALFA, 2 MG AND HYALURONIDASE-QVFC	Healthcare Administered Drugs	Y				
J9341	INJ, THIOTEPA (TEPYLUTE), 1 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y

J9342	INJ, THIOTEPA, NOT OTHRWS SPCFD, 1 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9345	INJECTION, RETIFANLIMAB-DLWR, 1 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9347	INJECTION, TREMELIMUMAB-ACTL, 1 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9348	INJECTION NAXITAMAB-GQGK 1 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9349	INJECTION, TAFASITAMAB-CXIX, 2 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9350	INJECTION, MOSUNETUZUMAB-AXGB, 1 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9351	INJECTION TOPOTECAN 0.1 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9352	INJECTION TRABECTEDIN 0.1 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9353	INJECTION MARGETUXIMAB-CMKB 5 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9354	INJ ADO-TRASTUZUMAB EMTANSINE 1 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9355	INJECTION TRASTUZUMAB EXCLUDES BIOSIMILAR 10 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9356	INJECTION TRASTUZUMAB 10 MG AND HYALURONIDASE-OYSK	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9357	INJECTION VALRUBICIN INTRAVESICAL 200 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9358	INJECTION, FAM-TRASTUZUMAB DERUXTECAN-NXKI, 1 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9359	INJECTION, LONCASTUXIMAB TESIRINE-LPYL, 0.075 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9360	INJECTION VINBLASTINE SULFATE 1 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9361	INJ, EFBEMALENOGRASTIM ALFA-VUXW, 0.5 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9370	VINCRISTINE SULFATE 1 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9376	INJECTION, POZELIMAB-BBFG, 1 MG	Healthcare Administered Drugs	Y				
J9380	INJECTION, TECLISTAMAB-CQYV, 0.5 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9381	INJECTION, TEPLIZUMAB-MZWV, 5 MCG	Healthcare Administered Drugs	Y				
J9382	INJ, ZENOCUTUZUMAB-ZBCO, 1 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9390	INJECTION VINORELBINE TARTRATE 10 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9393	INJ, FULVESTRANT (TEVA)	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		
J9394	INJ, FULVESTRANT (FRESENIUS)	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		
J9395	INJECTION FULVESTRANT 25 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
J9400	INJECTION ZIV-AFLIBERCEPT 1 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9600	INJECTION PORFIMER SODIUM 75 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
J9999	NOT OTHERWISE CLASSIFIED ANTINEOPLASTIC DRUG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis, direct outpatient requests for drugs within Evolent scope to Evolent. For Pediatrics, inpatient, non-oncology requests, or drugs out of Evolent scope direct request to the healthplan.		Y
Q0138	INJ FERUMOXYTOL TX IRON DEF ANEMIA 1 MG NON-ESRD	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
Q0139	INJ FERUMOXYTOL TX IRON DEF ANEMIA 1 MG FOR ESRD	Healthcare Administered Drugs	Y				
Q0224	INJ, PEMIVIBART, 4500 MG	Healthcare Administered Drugs	Y				
Q2017	INJECTION TENIPOSIDE 50 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
Q2049	INJ DOXORUBICIN HCL LIP IMPORTED LIPODOX 10 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
Q2050	INJECTION DOXORUBICIN HCL LIPOSOMAL NOS 10 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
Q3027	INJECTION INTERFERON BETA-1A 1 MCG IM USE	Healthcare Administered Drugs	Y				
Q3028	INJECTION INTERFERON BETA-1A 1 MCG SUBQ USE	Healthcare Administered Drugs	Y				
Q4074	ILOPROST INHAL SOL THRU DME UNIT DOSE TO 20 MCG	Healthcare Administered Drugs	Y				
Q5098	INJ, USTEKINUMAB-SRLF (IMULDOSA), BIOSIMILAR, 1 MG	Healthcare Administered Drugs	Y				
Q5099	INJ, USTEKINUMAB-STBA (STEQEYMA), BIOSIMILAR, 1 MG	Healthcare Administered Drugs	Y				
Q5100	INJ, USTEKINUMAB-KFCE (YESINTEK), BIOSIMILAR, 1 MG	Healthcare Administered Drugs	Y				
Q5101	INJECTION FILGRASTIM BIOSIMILAR 1 MCG	Healthcare Administered Drugs	~	Y*	KY: If requesting this drug for delivery by a pharmacy, please visit kyportal.medimpact.com for authorization information. This drug is reviewed by MedImpact when requested under the Pharmacy Benefit. *Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non-cancer diagnosis or inpatient, direct request to the healthplan. Pediatric members do not require PA for outpatient.		Y/MedImpact
Q5103	INJECTION INFLIXIMAB-DYYB BIOSIMILAR 10 MG	Healthcare Administered Drugs	Y				
Q5104	INJECTION INFLIXIMAB-ABDA BIOSIMILAR 10 MG	Healthcare Administered Drugs	Y				
Q5106	INJECTION EPOETIN ALFA-EPBX BIOSIMILAR 1000 U	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
Q5107	INJECTION BEVACIZUMAB-AWWB BIOSIMILAR 10 MG	Healthcare Administered Drugs	Y	Y*	Bevacizumab when billed for intracular injection does not require PA. *Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
Q5108	INJECTION PEGFILGRASTIM-JMDB BIOSIMILAR 0.5 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
Q5109	INJECTION INFLIXIMAB-QBTX BIOSIMILAR 10 MG	Healthcare Administered Drugs	Y				
Q5110	INJECTION FILGRASTIM-AAFI BIOSIMILAR 1 MCG	Healthcare Administered Drugs	~	Y*	KY: If requesting this drug for delivery by a pharmacy, please visit kyportal.medimpact.com for authorization information. This drug is reviewed by MedImpact when requested under the Pharmacy Benefit. *Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non-cancer diagnosis or inpatient, direct request to the healthplan. Pediatric members do not require PA for outpatient.		Y/MedImpact
Q5111	INJECTION PEGFILGRASTIM-CBQV BIOSIMILAR 0.5 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
Q5112	INJECTION TRASTUZUMAB-DTTB BIOSIMILAR 10 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
Q5113	INJECTION TRASTUZUMAB-PKRB BIOSIMILAR 10 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
Q5114	INJECTION TRASTUZUMAB-DKST BIOSIMILAR 10 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
Q5115	INJECTION RITUXIMAB-ABBS BIOSIMILAR 10 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
Q5116	INJECTION, TRASTUZUMAG-QYYP, BIOSIMILAR, (TRAZIMERA), 10 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
Q5117	INJECTION, TRASTUZUMAB-ANNS, BIOSIMILAR, (KANJINTI), 10 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
Q5118	INJECTION, BEVACIZUMAB-BVZR, BIOSIMILAR, (ZIRABEV), 10 MG	Healthcare Administered Drugs	Y	Y*	Bevacizumab when billed for intracular injection does not require PA. *Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
Q5119	INJECTION, RITUXIMAB-PVVR, BIOSIMILAR, (RUXIENCE), 10 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
Q5120	INJECTION, PEGFILGRASTIM-BMEZ, BIOSIMILAR, (ZIEXTENZO), 0.5 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
Q5121	INJECTION, INFLIXIMAB-AXXQ, BIOSIMILAR, (AVSOLA), 10 MG	Healthcare Administered Drugs	Y				
Q5122	INJECTION, PEGFILGRASTIM-APGF, BIOSIMILAR, (NYVEPRIA), 0.5 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
Q5123	INJECTION RITUXIMAB-ARRX BIOSIMILAR 10 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
Q5124	INJECTION RANIBIZUMAB-NUNA BS BYOOVIZ 0.1 MG	Healthcare Administered Drugs	Y				
Q5125	INJ FILGRASTIM-AYOW BIOSIMILAR RELEUKO 1 MCG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
Q5126	BEVACIZUMAB-MALY, BIOSIMILAR	Healthcare Administered Drugs	Y	Y*	Bevacizumab when billed for intracular injection does not require PA. *Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
Q5127	INJECTION, PEGFILGRASTIM-FPGK (STIMUFEND), BIOSIMILAR, 0.5 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
Q5128	INJECTION, RANIBIZUMAB-EQRN (CIMERLI), BIOSIMILAR, 0.1 MG	Healthcare Administered Drugs	Y				
Q5129	INJECTION, BEVACIZUMAB-ADCD (VEGZELMA), BIOSIMILAR, 10 MG	Healthcare Administered Drugs	Y	Y*	Bevacizumab when billed for intracular injection does not require PA. *Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
Q5130	INJECTION, PEGFILGRASTIM-PBBK (FYLNETRA), BIOSIMILAR, 0.5 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
Q5133	INJECTION, TOCILIZUMAB-BAVI (TOFIDENCE), BIOSIMILAR, 1 MG	Healthcare Administered Drugs	Y				
Q5134	INJECTION, NATALIZUMAB-SZTN (TYRUKO), BIOSIMILAR, 1 MG	Healthcare Administered Drugs	Y				
Q5135	INJ, TOCILIZUMAB-AAZG (TYENNE), BIOSIMILAR, 1 MG	Healthcare Administered Drugs	Y				
Q5136	INJ, DENOSUMAB-BBDZ (JUBBONTI/WYOST), BIOSIMILAR, 1 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
Q5137	INJ, USTEKINUMAB-AUUB (WEZLANA), BIOSIMILAR, SUBCUTANEOUS, 1 MG	Healthcare Administered Drugs	Y				
Q5138	INJ, USTEKINUMAB-AUUB (WEZLANA), BIOSIMILAR, INTRAVENOUS, 1 MG	Healthcare Administered Drugs	Y				
Q5140	INJ, ADALIMUMAB-FKJP, BIOSIMILAR, 1 MG	Healthcare Administered Drugs	Y				
Q5141	INJ, ADALIMUMAB-AATY, BIOSIMILAR, 1 MG	Healthcare Administered Drugs	Y				
Q5142	INJ, ADALIMUMAB-RYVK BIOSIMILAR, 1 MG	Healthcare Administered Drugs	Y				
Q5143	INJ, ADALIMUMAB-ADBM, BIOSIMILAR, 1 MG	Healthcare Administered Drugs	Y				
Q5144	INJ, ADALIMUMAB-AACF (IDACIO), BIOSIMILAR, 1 MG	Healthcare Administered Drugs	Y				
Q5145	INJ, ADALIMUMAB-AFZB (ABRILADA), BIOSIMILAR, 1 MG	Healthcare Administered Drugs	Y				
Q5146	INJ, TRASTUZUMAB-STRF (HERCESSI), BIOSIMILAR, 10 MG	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
Q5147	INJ, AFLIBERCEPT-AYYH (PAVBLU), BIOSIMILAR, 1 MG	Healthcare Administered Drugs	Y				
Q5148	INJ, FILGRASTIM-TXID (NYPOZI), BIOSIMILAR, 1 MICROGRAM	Healthcare Administered Drugs	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
Q5149	INJECTION, AFLIBERCEPT-ABZV (ENZEEVU), BIOSIMILAR, 1 MG	Healthcare Administered Drugs	Y				
Q5150	INJ, AFLIBERCEPT-MRBB (AHZANTIVE), BIOSIMILAR, 1 MG	Healthcare Administered Drugs	Y				
Q5151	INJ, ECULIZUMAB-AAGH (EPYSQLI), BIOSIMILAR, 2 MG	Healthcare Administered Drugs	Y				
Q5152	INJ, ECULIZUMAB-AEEB (BKEMV), BIOSIMILAR, 2 MG	Healthcare Administered Drugs	Y				
Q5153	INJ, AFLIBERCEPT-YSZY (OPUVIZ), BIOSIMILAR, 1 MG	Healthcare Administered Drugs	Y				
Q9996	INJ, USTEKINUMAB-TTWE (PYZCHIVA), SUBCUTANEOUS, 1 MG	Healthcare Administered Drugs	Y				
Q9997	INJ, USTEKINUMAB-TTWE (PYZCHIVA), INTRAVENOUS, 1 MG	Healthcare Administered Drugs	Y				
Q9998	INJ, USTEKINUMAB-AEKN (SELARSDI), 1 MG	Healthcare Administered Drugs	Y				
Q9999	INJ, USTEKINUMAB-AAUZ (OTULFI), BIOSIMILAR, 1 MG	Healthcare Administered Drugs	Y				
S0013	ESKETAMINE, NASAL SPRAY, 1 MG	Healthcare Administered Drugs	Y				
S0122	INJECTION MENOTROPINS 75 IU	Healthcare Administered Drugs	Y				
S0126	INJECTION FOLLITROPIN ALFA 75 IU	Healthcare Administered Drugs	Y				
S0128	INJECTION FOLLITROPIN BETA 75 IU	Healthcare Administered Drugs	Y				
S0132	INJECTION GANIRELIX ACETATE 250 MCG	Healthcare Administered Drugs	Y				
S0145	INJ PEGYLATED INTERFERON ALFA2A 180 MCG PER ML	Healthcare Administered Drugs	Y				
S0148	INJECTION PEGYLATED INTERFERON ALFA-2B 10 MCG	Healthcare Administered Drugs	Y				
S0156	EXEMESTANE 25 MG	Healthcare Administered Drugs	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
S0157	BECAPLERMIN GEL 0.01PCT 0.5 GM	Healthcare Administered Drugs	Y				
S0189	TESTOSTERONE PELLET 75 MG	Healthcare Administered Drugs	Y				
S1091	STENT NONCORONARY TEMPORARY WITH DELIVERY SYSTEM	Healthcare Administered Drugs	Y				
G0151	SRVCS PRFRMD BY PHYSCN THRPY HH OR HSPCE EA 15 MIN	Home Health Care Services	Y				
G0152	SRVCS PRFRMD BY OCCPNL THRPST HH OR HSPCE EA 15 MIN	Home Health Care Services	Y				
G0153	SRVCS SPCH&LNGGE PTHLGST HH OR HSPCE EA 15 MIN	Home Health Care Services	Y				
G0155	SRVC CLINICAL SOCIAL WORKER HH HOSPICE EA 15 MIN	Home Health Care Services	Y				
G0156	SRVC HH/HOSPICE AIDE IN HH/HOSPICE SET EA 15 MIN	Home Health Care Services	Y				
G0157	SERVICES BY PT ASSIST HOME HEALTH HOSPICE EA 15 MIN	Home Health Care Services	Y				
G0158	SERVICE OT ASSISTNT HOME HEALTH HOSPICE EA 15 MIN	Home Health Care Services	Y				
G0159	SERVICES PT HOME HEALTH EST DEL PT MP EA 15 MINS	Home Health Care Services	Y				
G0160	SERVICES OT HOME HEALTH EST DEL OT MP EA 15 MINS	Home Health Care Services	Y				
G0161	SERVICE SLP HH EST DEL SPCH-LANG PATH MP EA 15 M	Home Health Care Services	Y				
G0162	SKILLED SVCE BY RN E&M PLAN OF CARE; EA 15 MINS	Home Health Care Services	Y				
G0299	DIRECT SNS RN HOME HEALTH/HOSPICE SET EA 15 MIN	Home Health Care Services	Y				
G0300	DIRECT SNS LPN HOME HLTH HOSPICE SET EA 15 MIN	Home Health Care Services	Y				
G0490	FACE-TO-FACE HH NSG VST RHC FQHC AREA SHTG HHA	Home Health Care Services	Y				
G0493	SKILLED SERVICES RN OBV AND ASMNT PT CONDTN EA 15 MIN	Home Health Care Services	Y				
G0494	SKILLED SRVC LPN OBS AND ASMT PT COND EA 15 MIN	Home Health Care Services	Y				
G0495	SKD SRVC RN TRAIN AND EDU PT FAM HH HOSPC EA 15 MIN	Home Health Care Services	Y				
G0496	SKD SRVC LPN TRAIN AND EDU PT FAM HH HOSPC E 15 MIN	Home Health Care Services	Y				
S5111	HOME CARE TRAINING FAMILY; PER SESSION	Home Health Care Services	Y				
S5116	HOME CARE TRAINING NON-FAMILY; PER SESSION	Home Health Care Services	Y				
S5130	HOMEMAKER SERVICE NOS; PER 15 MINUTES	Home Health Care Services	Y				
S5135	COMPANION CARE ADULT ; PER 15 MINUTES	Home Health Care Services	Y				
S5150	UNSKILLED RESPITE CARE NOT HOSPICE; PER 15 MIN	Home Health Care Services	Y				
S5151	UNSKILLED RESPITE CARE NOT HOSPICE; PER DIEM	Home Health Care Services	Y				
S5165	HOME MODIFICATIONS; PER SERVICE	Home Health Care Services	Y				
S9122	HOM HLTH AIDE/CERT NURSE ASST PROV CARE HOM; /HR	Home Health Care Services	Y				
S9123	NURSING CARE THE HOME; REGISTERED NURSE PER HOUR	Home Health Care Services	Y				
S9124	NURSING CARE IN THE HOME; BY LPN PER HOUR	Home Health Care Services	Y				
S9128	SPEECH THERAPY IN THE HOME PER DIEM	Home Health Care Services	Y				
S9129	OCCUPATIONAL THERAPY IN THE HOME PER DIEM	Home Health Care Services	Y				
S9131	PHYSICAL THERAPY; IN THE HOME PER DIEM	Home Health Care Services	Y				
S9470	NUTRITIONAL COUNSELING DIETITIAN VISIT	Home Health Care Services	Y				
S9977	MEALS PER DIEM NOT OTHERWISE SPECIFIED	Home Health Care Services	Y				
T1000	PRIV DUTY INDEPEND NRS SERVICE LIC UP 15 MIN	Home Health Care Services	Y				
T1002	RN SERVICES UP TO 15 MINUTES	Home Health Care Services	Y				
T1003	LPN LVN SERVICES UP TO 15 MINUTES	Home Health Care Services	Y				
T1005	RESPITE CARE SERVICES UP TO 15 MINUTES	Home Health Care Services	Y				
T1019	PERSONAL CARE SERVICES PER 15 MINUTES	Home Health Care Services	Y				
T1022	CONTRACT HOME HEALTH SRVC UNDER CONTRACT DAY	Home Health Care Services	Y				
T1030	NURSING CARE IN THE HOME RN PER DIEM	Home Health Care Services	Y				
T1031	NURSING CARE IN THE HOME BY LPN PER DIEM	Home Health Care Services	Y				
15271	APP SKN SUB GRFT T/A/L AREA/100SQ.CM OR LT 1ST 25	Hyperbaric/Wound Therapy	Y				
15272	APP SKN SUB GRFT T/A/L AREA/100SQ.CM EA ADL 25SC	Hyperbaric/Wound Therapy	Y				
15273	APP SKN SUBGRFT T/A/L AREA/100SQ.CM 1ST 100SQ.CM	Hyperbaric/Wound Therapy	Y				
15274	APP SKN SUB GRFT T/A/L AREA GT or equal to 100SCM ADL 100S	Hyperbaric/Wound Therapy	Y				
15275	SUB GRFT F/S/N/H/F/G/M/D LT 100SQ CM 1ST 25 SQ CM	Hyperbaric/Wound Therapy	Y				
15276	SUB GRFT F/S/N/H/F/G/M/D LT 100SQ.CM EA ADDL25SQ.CM	Hyperbaric/Wound Therapy	Y				
15277	SUB GRFT F/S/N/H/F/G/M/D GT or equal to 100SCM 1ST 100SQ	Hyperbaric/Wound Therapy	Y				
15278	SUB GRFT F/S/N/H/F/G/M/D GT or equal to 100SCM ADL 100SQ	Hyperbaric/Wound Therapy	Y				
99183	PHYS QHP ATTN AND SUPVJ HYPRBARIC OXYGEN TX SESSION	Hyperbaric/Wound Therapy	Y				
A2001	INNOVAMATRIX AC PER SQ CM	Hyperbaric/Wound Therapy	Y				
A2002	MIRRAGEN ADVANCED WOUND MATRIX PER SQ CM	Hyperbaric/Wound Therapy	Y				
A2005	MICROLYTE MATRIX PER SQ CM	Hyperbaric/Wound Therapy	Y				
A2019	KERECIS OMEGA3 MARIGEN SHIELD PER SQ CM	Hyperbaric/Wound Therapy	Y				
A2020	AC5 ADVANCED WOUND SYSTEM	Hyperbaric/Wound Therapy	Y				
A2021	NEOMATRIX PER SQ CM	Hyperbaric/Wound Therapy	Y				
G0277	HPO UND PRESS FULL BODY CHMBR PER 30 MIN INT	Hyperbaric/Wound Therapy	Y				
Q4101	APLIGRAF PER SQ CM	Hyperbaric/Wound Therapy	Y				
Q4106	DERMAGRAFT PER SQ CM	Hyperbaric/Wound Therapy	Y				
Q4121	THERASKIN PER SQ CM	Hyperbaric/Wound Therapy	Y				
Q4125	ARTHROFLEX PER SQ CM	Hyperbaric/Wound Therapy	Y				
Q4126	MEMODERM DERMASPAN TRANZGRFT INTEGUPLY PER SQ CM	Hyperbaric/Wound Therapy	Y				
Q4128	FLEXHD ALLOPATCHHD OR MATRIX HD PER SQ CM	Hyperbaric/Wound Therapy	Y				
Q4130	STRATTICE PER SQ CM	Hyperbaric/Wound Therapy	Y				
Q4132	GRAFIX CORE AND GRAFIXPL CORE PER SQUARE CM	Hyperbaric/Wound Therapy	Y				
Q4133	GRAFIX PRIME AND GRAFIXPL PRIME PER SQUARE CM	Hyperbaric/Wound Therapy	Y				
Q4150	ALLOWRAP DS OR DRY PER SQUARE CENTIMETER	Hyperbaric/Wound Therapy	Y				
Q4151	AMNIOBAND OR GUARDIAN PER SQUARE CENTIMETER	Hyperbaric/Wound Therapy	Y				
Q4156	NEOX 100 OR CLARIX 100 PER SQUARE CM	Hyperbaric/Wound Therapy	Y				
Q4157	REVITALON PER SQUARE CENTIMETER	Hyperbaric/Wound Therapy	Y				
Q4158	KERECIS OMEGA3 PER SQUARE CM	Hyperbaric/Wound Therapy	Y				
Q4159	AFFINITY PER SQUARE CENTIMETER	Hyperbaric/Wound Therapy	Y				
Q4160	NUSHIELD PER SQUARE CENTIMETER	Hyperbaric/Wound Therapy	Y				
Q4162	WOUNDEX FLOW BIOSKIN FLOW 0.5 CC	Hyperbaric/Wound Therapy	Y				
Q4163	WOUNDEX BIOSKIN PER SQUARE CM	Hyperbaric/Wound Therapy	Y				
Q4164	HELICOLL PER SQUARE CENTIMETER	Hyperbaric/Wound Therapy	Y				
Q4178	FLOWERAMNIOPATCH PER SQUARE CM	Hyperbaric/Wound Therapy	Y				
Q4179	FLOWERDERM PER SQUARE CM	Hyperbaric/Wound Therapy	Y				
Q4180	REVITA PER SQUARE CM	Hyperbaric/Wound Therapy	Y				
Q4181	AMNIO WOUND PER SQUARE CM	Hyperbaric/Wound Therapy	Y				
Q4182	TRANSCYTE PER SQUARE CM	Hyperbaric/Wound Therapy	Y				
Q4186	EPIFIX PER SQ CM	Hyperbaric/Wound Therapy	Y				
Q4187	EPICORD PER SQ CM	Hyperbaric/Wound Therapy	Y				
Q4191	RESTORIGIN, PER SQUARE CENTIMETER	Hyperbaric/Wound Therapy	Y				
Q4194	NOVACHOR PER SQ CM	Hyperbaric/Wound Therapy	Y				
Q4195	PURAPLY PER SQ CM	Hyperbaric/Wound Therapy	Y				
Q4196	PURAPLY AM PER SQ CM	Hyperbaric/Wound Therapy	Y				
Q4197	PURAPLY XT PER SQ CM	Hyperbaric/Wound Therapy	Y				
Q4203	DERMA-GIDE PER SQ CM	Hyperbaric/Wound Therapy	Y				
Q4204	XWRAP PER SQ CM	Hyperbaric/Wound Therapy	Y				
Q4205	MEMBRANE GRAFT OR MEMBRANE WRAP PER SQ CM	Hyperbaric/Wound Therapy	Y				
Q4215	AXOLOTL AMBIENT OR AXOLOTL CRYO 0.1 MG	Hyperbaric/Wound Therapy	Y				
Q4218	SURGICORD PER SQ CM	Hyperbaric/Wound Therapy	Y				
Q4219	SURGIGRAFT-DUAL PER SQ CM	Hyperbaric/Wound Therapy	Y				
Q4221	AMNIO WRAP2 PER SQ CM	Hyperbaric/Wound Therapy	Y				
Q4227	AMNIOCORE, PER SQUARE CENTIMETER	Hyperbaric/Wound Therapy	Y				
Q4229	COGENEX AMNIOTIC MEMBRANE, PER SQUARE CENTIMETER	Hyperbaric/Wound Therapy	Y				
Q4231	CORPLEX P PER CC	Hyperbaric/Wound Therapy	Y				
Q4236	CAREPATCH, PER SQUARE CENTIMETER	Hyperbaric/Wound Therapy	Y				
Q4238	DERM-MAXX PER SQ CM	Hyperbaric/Wound Therapy	Y				
Q4240	CORECYTE FOR TOPICAL USE ONLY PER 0.5 CC	Hyperbaric/Wound Therapy	Y				
Q4248	DERMACYTE AMNIOTIC MEMBRANE ALLOGRAFT, PER SQUARE CENTIMETER	Hyperbaric/Wound Therapy	Y				
Q4250	AMNIOAMP-MP, PER SQUARE CENTIMETER	Hyperbaric/Wound Therapy	Y				
Q4252	VENDAJE PER SQ CM	Hyperbaric/Wound Therapy	Y				
Q4265	NEOSTIM TL, PER SQUARE CENTIMETER	Hyperbaric/Wound Therapy	Y				
Q4266	NEOSTIM MEMBRANE, PER SQUARE CENTIMETER	Hyperbaric/Wound Therapy	Y				
Q4267	NEOSTIM DL, PER SQUARE CENTIMETER	Hyperbaric/Wound Therapy	Y				
Q4268	SURGRAFT FT, PER SQUARE CENTIMETER	Hyperbaric/Wound Therapy	Y				
Q4269	SURGRAFT XT, PER SQUARE CENTIMETER	Hyperbaric/Wound Therapy	Y				
Q4270	COMPLETE SL, PER SQUARE CENTIMETER	Hyperbaric/Wound Therapy	Y				
Q4271	COMPLETE FT, PER SQUARE CENTIMETER	Hyperbaric/Wound Therapy	Y				
Q4272	ESANO A, PER SQ CM	Hyperbaric/Wound Therapy	Y				
Q4273	ESANO AAA, PER SQ CM	Hyperbaric/Wound Therapy	Y				
Q4274	ESANO AC, PER SQ CM	Hyperbaric/Wound Therapy	Y				
Q4275	ESANO ACA, PER SQ CM	Hyperbaric/Wound Therapy	Y				
Q4276	ORION, PER SQ CM	Hyperbaric/Wound Therapy	Y				
Q4278	EPIEFFECT, PER SQ CM	Hyperbaric/Wound Therapy	Y				
Q4280	XCELL AMNIO MATRIX, PER SQ CM	Hyperbaric/Wound Therapy	Y				
Q4281	BARRERA SL OR BARRERA DL, PER SQ CM	Hyperbaric/Wound Therapy	Y				
Q4282	CYGNUS DUAL, PER SQ CM	Hyperbaric/Wound Therapy	Y				
Q4283	BIOVANCE TRI-LAYER OR BIOVANCE 3L, PER SQ CM	Hyperbaric/Wound Therapy	Y				
Q4284	DERMABIND SL, PER SQ CM	Hyperbaric/Wound Therapy	Y				
Q4294	AMNIO QUAD-CORE PER SQ CM	Hyperbaric/Wound Therapy	Y				
Q4295	AMNIO TRI-CORE AMNIOTIC PER SQ CM	Hyperbaric/Wound Therapy	Y				
Q4299	AMNICORE PRO Plus PER SQ CM	Hyperbaric/Wound Therapy	Y				
Q4326	WOUNDPLUS, PER SQUARE CENTIMETER	Hyperbaric/Wound Therapy	Y				
70450	CT HEAD BRAIN W O CONTRAST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
70460	CT HEAD BRAIN W CONTRAST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
70470	CT HEAD BRAIN W O AND W CONTRAST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
70496	CT ANGIOGRAPHY HEAD W CONTRAST NONCONTRAST	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
70498	CT ANGIOGRAPHY NECK W CONTRAST NONCONTRAST	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
70540	MRI ORBIT FACE AND NECK W O CONTRAST	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
70542	MRI ORBIT FACE AND NECK W CONTRAST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
70543	MRI ORBIT FACE AND NECK W O AND W CONTRAST MATRL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
70544	MRA HEAD W O CONTRST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
70545	MRA HEAD W CONTRAST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
70546	MRA HEAD W O AND W CONTRAST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
70547	MRA NECK W O CONTRST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
70548	MRA NECK W CONTRAST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		

70549	MRA NECK W O AND W CONTRAST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
70551	MRI BRAIN BRAIN STEM W O CONTRAST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
70552	MRI BRAIN BRAIN STEM W CONTRAST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
70553	MRI BRAIN BRAIN STEM W O W CONTRAST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
70554	MRI BRAIN FUNCTIONAL W O PHYSICIAN ADMINISTRATION	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
70555	MRI BRAIN FUNCTIONAL W PHYSICIAN ADMINISTRATION	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
71275	CT ANGIOGRAPHY CHEST W CONTRAST NONCONTRAST	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
71550	MRI CHEST W O CONTRAST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
71551	MRI CHEST W CONTRAST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
71552	MRI CHEST W O AND W CONTRAST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
71555	MRA CHEST W O AND W CONTRAST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
72128	CT THORACIC SPINE W O CONTRAST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
72129	CT THORACIC SPINE W CONTRAST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
72130	CT THORACIC SPINE W O AND W CONTRAST MTRL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
72131	CT LUMBAR SPINE W O CONTRAST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
72132	CT LUMBAR SPINE W CONTRAST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
72133	CT LUMBAR SPINE W O AND W CONTRAST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
72141	MRI SPINAL CANAL CERVICAL W O CONTRAST MATRL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
72142	MRI SPINAL CANAL CERVICAL W CONTRAST MATRL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
72146	MRI SPINAL CANAL THORACIC W O CONTRAST MATRL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
72147	MRI SPINAL CANAL THORACIC W CONTRAST MATRL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
72148	MRI SPINAL CANAL LUMBAR W O CONTRAST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
72149	MRI SPINAL CANAL LUMBAR W CONTRAST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
72156	MRI SPINAL CANAL CERVICAL WO AND W CONTR MTRL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
72157	MRI SPINAL CANAL THORACIC WO FF BY W CNTRST MTRL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
72158	MRI SPINAL CANAL LUMBAR WO FF BY W CNTRST MTRL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
72159	MRA SPINAL CANAL W WO CONTRAST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
72191	CT ANGIOGRAPHY PELVIS W CONTRAST NONCONTRAST	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
72192	CT PELVIS W O CONTRAST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
72193	CT PELVIS W CONTRAST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
72194	CT PELVIS W O AND W CONTRAST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
72195	MRI PELVIS W O CONTRAST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
72196	MRI PELVIS W CONTRAST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
72197	MRI PELVIS W O AND W CONTRAST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
72198	MRA PELVIS W WO CONTRAST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
73218	MRI UPPER EXTREMITY OTH THAN JT W O CONTR MATRL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
73219	MRI UPPER EXTREMITY OTH THAN JT W CONTR MATRL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
73220	MRI UPPER EXTREM OTHER THAN JT W O AND W CONTRAS	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
73221	MRI ANY JT UPPER EXTREMITY W O CONTRAST MATRL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
73222	MRI ANY JT UPPER EXTREMITY W CONTRAST MATRL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
73223	MRI ANY JT UPPER EXTREMITY W O AND W CONTR MATRL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
73225	MRA UPPER EXTREMITY W WO CONTRAST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
73718	MRI LOWER EXTREM OTH THN JT W O CONTR MATRL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
73719	MRI LOWER EXTREM OTH THN JT W CONTRAST MATRL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
73720	MRI LOWER EXTREM OTH THN JT W O AND W CONTR MATR	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
73721	MRI ANY JT LOWER EXTREM W O CONTRAST MATRL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
73722	MRI ANY JT LOWER EXTREM W CONTRAST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
73723	MRI ANY JT LOWER EXTREM W O AND W CONTRAST MATRL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
73725	MRA LOWER EXTREMITY W WO CONTRAST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
74150	CT ABDOMEN W O CONTRAST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
74160	CT ABDOMEN W CONTRAST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
74170	CT ABDOMEN W O AND W CONTRAST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
74174	CT ANGIO ABD AND PLVIS CNTRST MTRL W WO CNTRST IMG	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
74175	CT ANGIOGRAPHY ABDOMEN W CONTRAST NONCONTRAST	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
74176	CT ABDOMEN AND PELVIS W O CONTRAST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
74177	CT ABDOMEN AND PELVIS W CONTRAST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
74178	CT ABDOMEN AND PELVIS W O CONTRST 1 OR GRT BODY RE	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
74181	MRI ABDOMEN W O CONTRAST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
74182	MRI ABDOMEN W CONTRAST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
74183	MRI ABDOMEN W O AND W CONTRAST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
74185	MRA ABDOMEN W WO CONTRAST MATERIAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
74261	CT COLONOGRAPHY DX IMAGE POSTPROCESS W O CONTRAST	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
74262	CT COLONOGRAPHY DX IMAGE POSTPROCESS W CONTRAST	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
74263	CT COLONOGRAPHY SCREENING IMAGE POSTPROCESSING	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
75557	CARDIAC MRI MORPHOLOGY & FUNCTION W/O CONTRAST	Imaging & Special Tests	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
75559	CARDIAC MRI W CONTRAST W STRESS IMAGING	Imaging & Special Tests	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
75561	CARDIAC MRI W/WO CONTRAST & FURTHER SEQ	Imaging & Special Tests	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
75563	CARDIAC MRI WO FF BY W CNTRST W STRESS IMGNG	Imaging & Special Tests	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
75565	CARDIAC MRI FOR VELOCITY FLOW MAPPING	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
75571	CT HEART NO CONTRAST QUANT EVAL CORONRY CALCIUM	Imaging & Special Tests	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
75572	CT HEART CONTRAST EVAL CARDIAC STRUCTURE AND MORPH	Imaging & Special Tests	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
75573	CT HRT CONTRST CARDIAC STRUCT&MORPH CONG HRT D	Imaging & Special Tests	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
75574	CTA HRT CORNRY ART/BYPASS GRFTS CONTRST 3D POST	Imaging & Special Tests	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
75625	AORTOGRAPHY ABDOMINAL SERIALOGRAPHY RS&I	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
75630	AORTOGRAPHY ABDL BI ILIOFEM LOW EXTREM CATH RS&I	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
75635	CTA ABDL AORTA AND BI ILIOFEM W CONTRAST AND POSTP	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
75710	ANGIOGRAPHY EXTREMITY UNILATERAL RS&I	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send	Y	
75716	ANGIOGRAPHY EXTREMITY BILATERAL RS&I	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
75726	ANGIOGRAPHY VISCERAL SLCTV/SUPRASLCTV RS&I	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
75736	ANGIOGRAPHY PELVIC SLCTV/SUPRASLCTV RS&I	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
75820	VENOGRAPHY EXTREMITY UNILATERAL RS&I	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
75822	VENOGRAPHY EXTREMITY BILATERAL RS&I	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
75825	VENOGRAPHY CAVAL INFERIOR SERIALOGRAPHY RS&I	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
75827	VENOGRAPHY CAVAL SUPERIOR SERIALOGRAPHY RS&I	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send	Y	
75860	VENOGRAPHY VENOUS SINUS/JUGULAR CATH RS&I	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
75898	ANGRPH CATH F-UP STD TCAT OTHER THAN THROMBYLSIS	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
76376	3D RENDERING W INTERP AND POSTPROCESS SUPERVISION	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
76377	3D RENDERING W INTERP AND POSTPROC DIFF WORK STATION	Imaging & Special Tests	Y		If submitting this code with another Advanced Imaging code, send request to Advanced Imaging. Otherwise, send request to the Health Plan. For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
76390	MRI SPECTROSCOPY	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
76391	MAGNETIC RESONANCE ELASTOGRAPHY	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
76497	UNLISTED COMPUTED TOMOGRAPHY PROCEDURE	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
76498	UNLISTED MAGNETIC RESONANCE PROCEDURE	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
76937	US VASC ACCESS SITS VSL PATENCY NDL ENTRY	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send	Y	
77046	MRI BREAST WITHOUT CONTRAST MATERIAL UNILATERAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
77047	MRI BREAST WITHOUT CONTRAST MATERIAL BILATERAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
77048	MRI BREAST W OUT AND WITH CONTRAST W CAD UNILATERAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
77049	MRI BREAST WITHOUT AND WITH CONTRAST W CAD BILATERAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
78414	CARD-VASC HEMODYNAM W WO PHARM EXER 1 MLT DETERM	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
78428	CARDIAC SHUNT DETECTION	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send	Y	
78429	MYOCRD IMG PET METAB EVAL SINGLE STUDY CNCRNT CT	Imaging & Special Tests	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
78430	MYOCRD IMG PET PRFUJ 1STD REST STRESS CNCRNT CT	Imaging & Special Tests	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
78431	MYOCRD IMG PET PRFUJ MLT STD RST AND STRS CNCRNT CT	Imaging & Special Tests	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
78432	MYOCRD IMG PET PRFUJ W METAB DUAL RADIOTRACER	Imaging & Special Tests	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
78433	MYOCRD IMG PET PRFUJ W METAB 2RTRACER CNCRNT CT	Imaging & Special Tests	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send	Y	
78451	MYOCARDIAL SPECT SINGLE STUDY AT REST OR STRESS	Imaging & Special Tests	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send	Y	
78452	MYOCARDIAL SPECT MULTIPLE STUDIES	Imaging & Special Tests	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send	Y	
78453	MYOCARDIAL PERFUSION PLANAR 1 STUDY REST/STRESS	Imaging & Special Tests	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send	Y	
78454	MYOCARDIAL PERFUSION PLANAR MULTIPLE STUDIES	Imaging & Special Tests	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send	Y	
78459	MYOCARDIAL IMAGING PET METABOLIC EVALUATION	Imaging & Special Tests	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send	Y	
78466	MYOCARDIAL IMAGING INFARCT AVID PLANAR QUAL/QUAN	Imaging & Special Tests	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send	Y	
78468	MYOCRD IMG INFARCT AVID PLNR EJEC FRJ 1ST PS TQ	Imaging & Special Tests	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send	Y	
78469	MYOCRD INFARCT AVID PLNR TOMOG SPECT W/WO QUANTJ	Imaging & Special Tests	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send	Y	
78472	CARD BLOOD POOL GATED PLANAR 1 STUDY REST/STRESS	Imaging & Special Tests	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send	Y	
78473	CARD BL POOL GATED MLT STDY WAL MOTN EJECT FRACT	Imaging & Special Tests	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send	Y	
78481	CARD BL POOL PLANAR 1 STDY WAL MOTN EJECT FRACT	Imaging & Special Tests	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
78483	CARD BL POOL PLNR MLT STDY WAL MOTN EJECT FRACT	Imaging & Special Tests	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send	Y	
78491	MYOCRD IMAGE PET PERFUS SINGLE STUDY REST/STRESS	Imaging & Special Tests	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send	Y	
78492	MYOCRD IMAGE PET PERFUS MULTPL STUDY REST/STRESS	Imaging & Special Tests	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
78494	CARD BL POOL GATED SPECT REST WAL MOTN EJCT FRCT	Imaging & Special Tests	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send	Y	
78499	UNLISTED CARDIOVASCULAR PX DX NUCLEAR MEDICINE	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
78608	BRAIN IMAGING PET METABOLIC EVALUATION	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
78609	BRAIN IMAGING PET PERFUSION EVALUATION	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
78811	PET IMAGING LIMITED AREA CHEST HEAD NECK	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
78812	PET IMAGING SKULL BASE TO MID-THIGH	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
78813	PET IMAGING WHOLE BODY	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
78814	PET IMAGING CT FOR ATTENUATION LIMITED AREA	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
78815	PET IMAGING CT ATTENUATION SKULL BASE MID-THIGH	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
78816	PET IMAGING FOR CT ATTENUATION WHOLE BODY	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
91113	GI TRACT IMAGING INTRALUMINAL COLON I AND R	Imaging & Special Tests	Y				
93241	EXTERNAL ECG REC GT 48HR LT 7D SCAN ALYS REPORT R AND I	Imaging & Special Tests	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send	Y	
93242	EXTERNAL ECG REC GT 48HR LT 7D RECORDING	Imaging & Special Tests	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send	Y	
93243	EXTERNAL ECG REC GT 48HR LT 7D SCANNING ALYS W/REPORT	Imaging & Special Tests	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send	Y	
93244	EXTERNAL ECG REC GT 48HR LT 7D REVIEW AND INTERPRETATION	Imaging & Special Tests	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send	Y	
93245	EXTERNAL ECG REC GT 7D LT 15D SCAN ALYS REPORT R AND I	Imaging & Special Tests	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
93246	EXTERNAL ECG REC GT 7D LT 15D RECORDING	Imaging & Special Tests	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send	Y	
93247	EXTERNAL ECG REC GT 7D LT 15D SCANNING ALYS W/REPORT	Imaging & Special Tests	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send	Y	
93248	EXTERNAL ECG REC GT 7D LT 15D REVIEW AND INTERPRETATION	Imaging & Special Tests	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send	Y	
93303	COMPLETE TTHRC ECHO CONGENITAL CARDIAC ANOMALY	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93304	F-UP/LIMITED TTHRC ECHO CONGENITAL CAR ANOMALY	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93306	ECHO TTHRC R-T 2D W/WOM-MODE COMPL SPEC&COLR D	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93307	ECHO TRANSTHORAC R-T 2D W/WO M-MODE REC COMP	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93308	ECHO TRANSTHORC R-T 2D W/WO M-MODE REC F-UP/LMTD	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93312	ECHO TRANSESOPHAG R-T 2D W/PRB IMG ACQUISTN I&R	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93313	ECHO R-T 2D W/PROBE PLACEMENT ONLY	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93314	ECHO TRANSESOPHAG R-T 2D IMG ACQUISTN I&R ONLY	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93315	ECHO TRANSESOPHAG CONGEN PROBE PLCMT IMGNG I&R	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send	Y	
93316	ECHO TRANSESOPHAG CONGEN PROBE PLCMT ONLY	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93317	ECHO TRANSESOPHAG IMAGE ACQUISN INTERP&REPORT	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93318	ECHO TRANSESOPHAG MONTR CARDIAC PUMP FUNCTJ	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93320	DOPPLER ECHOCARD PULSE WAVE W/SPECTRAL DISPLAY	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93325	DOP ECHOCARD COLOR FLOW VELOCITY MAPPING	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send	Y	
93350	ECHO TTHRC R-T 2D W M-MODE COMPLETE REST AND ST	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send	Y	
93351	ECHO TTHRC R-T 2D W M-MODE REST&STRS CONT ECG	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send	Y	
93355	ECHO TEE GUID TCAT ICAR/VESSEL STRUCTURAL INTVN	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send	Y	
93451	RIGHT HEART CATH O2 SATURATION & CARDIAC OUTPUT	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send	Y	
93452	L HRT CATH W/NJX L VENTRICULOGRAPHY IMG S&I	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send	Y	
93453	R & L HRT CATH W/NJX L VENTRCLGRPY IMG S&I	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send	Y	
93454	CATH PLACEMENT & NJX CORONARY ART ANGIO IMG S&I	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send	Y	
93455	CATH PLMT & NJX CORONARY ART/GRFT ANGIO IMG S&I	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send	Y	
93456	CATH PLMT R HRT & ARTS W/NJX & ANGIO IMG S&I	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send	Y	
93457	CATH PLMT R HRT/ARTS/GRFTS W/NJX& ANGIO IMG S&I	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send	Y	
93458	CATH PLMT L HRT & ARTS W/NJX & ANGIO IMG S&I	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send	Y	
93459	CATH PLMT L HRT/ARTS/GRFTS WNJX & ANGIO IMG S&I	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93460	R & L HRT CATH WNJX HRT ART& L VENTR IMG	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93461	R& L HRT CATH W/INJEC HRT ART/GRFT& L VENT I	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send	Y	
93880	DUPLEX SCAN EXTRACRANIAL ART COMPL BI STUDY	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93882	DUPLEX SCAN EXTRACRANIAL ART UNI/LMTD STUDY	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93895	CAROTID INTIMA MEDIA & CAROTID ATHEROMA EVAL BI	Imaging & Special Tests	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
93922	NON-INVAS PHYSIOLOGIC STD EXTREMITY ART 2 LEVEL	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93923	NON-INVASIVE PHYSIOLOGIC STUDY EXTREMITY 3 LEVLS	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93924	N-INVAS PHYSIOLOGIC STD LXTR ART COMPL BI	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93925	DUP-SCAN LXTR ART/ARTL BPGS COMPL BI STUDY	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93926	DUP-SCAN LXTR ART/ARTL BPGS UNI/LMTD STUDY	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93930	DUP-SCAN UXTR ART/ARTL BPGS COMPL BI STUDY	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93931	DUP-SCAN UXTR ART/ARTL BPGS UNI/LMTD STUDY	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93970	DUP-SCAN XTR VEINS COMPLETE BILATERAL STUDY	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93971	DUP-SCAN XTR VEINS UNILATERAL/LIMITED STUDY	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93975	DUP-SCAN ARTL FLO ABDL/PEL/SCROT&/RPR ORGN COM	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93978	DUP-SCAN AORTA IVC ILIAC VASCL/BPGS COMPLETE	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93979	DUP-SCAN AORTA IVC ILIAC VASCL/BPGS UNI/LMTD	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93990	DUPLEX SCAN HEMODIALYSIS ACCESS	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
0042T	CEREBRAL PERFUSION ANALYS CT W BLOOD FLOW AND VOLUME	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
0331T	MYOCRD SYMPATHETIC INNERVAJ IMG PLNR QUAL AND QUANT	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
0332T	MYOCRD SYMP INNERVAJ IMG PLNR QUAL AND QUANT W SPECT	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
0609T	MRS DISC PAIN ACQUISJ DATA	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
0610T	MRS DISC PAIN TRANSMIS DATA	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
0611T	MRS DISC PAIN ALG ALYS DATA	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
0612T	MRS DISCOGENIC PAIN I&R	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
0623T	AUTO QUAN AND CHARAC CORONARY ATHEROSCLEROTIC PLAQUE	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
0624T	AUTO QUAN AND CHARAC CORONARY PLAQ DATA PREP AND TRNSMIS	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
0625T	AUTO QUAN AND CHARAC CORONARY PLAQ COMPUTERIZED ALYS	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
0626T	AUTO QUAN AND CHARAC CORONARY PLAQ REV CPTR ALYS I AND R	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
0633T	CT BREAST W/3D RENDERING UNI WITHOUT CONTRAST	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
0634T	CT BREAST W/3D RENDERING UNI WITH CONTRAST	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
0635T	CT BRST W/3D RENDERING UNI WO CNTRST FLWD CNTRST	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
0636T	CT BREAST W/3D RENDERING BI WITHOUT CONTRAST	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
0637T	CT BREAST W/3D RENDERING BI WITH CONTRAST	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
0638T	CT BRST W/3D RENDERING BI WO CNTRST FLWD CNTRST	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
0689T	QUAN US TISS CHARAC I AND R W/O DX US SAME ANAT	Imaging & Special Tests	Y				
0710T	N-INVAS ARTL PLAQ ALYS DATA PRP QUAN REVIEW I AND R	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
0711T	N-INVAS ARTL PLAQ ALYS DATA PREP AND TRANSMISSION	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
0712T	N-INVAS ARTL PLAQ ALYS QUAN STRUX AND COMPOS VSL WAL	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
0713T	N-INVAS ARTL PLAQ ALYS DATA REVIEW I AND R	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
C8909	MR ANGIOGRAPHY WITH CONTRAST CHEST	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
C8910	MR ANGIOGRAPHY WITHOUT CONTRAST CHEST	Imaging & Special Tests	Y		For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal		
G0278	ILIAC&/FEM ART ANGIO NONSEL AT TIME CARD CATH	Imaging & Special Tests	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
95700	EEG CONT REC W VIDEO BY TECH MIN 8 CHANNELS	Neuropsychological and Psychological Tests	Y				
95705	EEG W O VID BY TECH EA INCR 12-26HR UNMONITORED	Neuropsychological and Psychological Tests	Y				
95709	EEG W O VID BY TECH EA INCR 12-26 HR INTMT MNTR	Neuropsychological and Psychological Tests	Y				
95710	EEG W O VID TECH EA INCR 12-26 HR CONT R-T MNTR	Neuropsychological and Psychological Tests	Y				

95711	VEEG BY TECH 2-12 HOURS UNMONITORED	Neuropsychological and Psychological Tests	Y				
95712	VEEG BY TECH 2-12 HR INTERMITTENT MONITORING	Neuropsychological and Psychological Tests	Y				
95713	VEEG BY TECH 2-12 HR CONTINUOUS R-T MONITORING	Neuropsychological and Psychological Tests	Y				
95714	VEEG BY TECH EA INCR 12-26 HR UNMONITORED	Neuropsychological and Psychological Tests	Y				
95715	VEEG BY TECH EA INCR 12-26 HR INTERMITTENT MNTR	Neuropsychological and Psychological Tests	Y				
95716	VEEG BY TECH EA INCR 12-26 HR CONT R-T MNTR	Neuropsychological and Psychological Tests	Y				
95721	EEG COMPLETE STD PHYS QHP OVER 36 HR UNDER 60 HR W O VIDEO	Neuropsychological and Psychological Tests	Y				
95722	EEG COMPLETE STD PHYS QHP OVER 36 HR UNDER 60 HR W VEEG	Neuropsychological and Psychological Tests	Y				
95723	EEG COMPLETE STD PHYS QHP OVER 60 HR UNDER 84 HR W O VIDEO	Neuropsychological and Psychological Tests	Y				
95724	EEG COMPLETE STD PHYS QHP OVER 60 HR UNDER 84 HR W VEEG	Neuropsychological and Psychological Tests	Y				
95725	EEG COMPLETE STD PHYS QHP OVER 84 HR W O VID	Neuropsychological and Psychological Tests	Y				
95726	EEG COMPLETE STD PHYS QHP OVER 84 HR W VEEG	Neuropsychological and Psychological Tests	Y				
95957	DIGITAL ANALYSIS ELECTROENCEPHALOGRAM	Neuropsychological and Psychological Tests	Y				
96125	STANDARDIZED COGNITIVE PERFORMANCE TESTING	Neuropsychological and Psychological Tests			See Ky Exceptions - No PA Required		
17360	CHEMICAL EXFOLIATION ACNE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
20560	NEEDLE INSERTION(S) WITHOUT INJ, 1 OR 2 MUSCLES	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
20561	NEEDLE INSERTION(S) WITHOUT INJ, 3 OR MORE MUSCLES	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
21073	MANIPULATION TMJ THERAPEUTIC REQUIRE ANESTHESIA	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
21120	GENIOPLASTY AUGMENTATION	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
21121	GENIOPLASTY SLIDING OSTEOTOMY SINGLE PIECE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
21122	GENIOPLASTY 2 OR GRT SLIDING OSTEOTOMIES	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
21123	GENIOP SLIDING AGMNTJ W INTERPOSAL BONE GRAFTS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
21125	AGMNTJ MNDBLR BODY ANGLE PROSTHETIC MATERIAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
21127	AGMNTJ MNDBLR BDY ANGL W GRF ONLAY INTERPOSAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
21137	REDUCTION FOREHEAD CONTOURING ONLY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
21138	RDCTJ FHD CNTRG AND PROSTHETIC MATRL BONE GRAFT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
21139	RDCTJ FHD CNTRG AND SETBACK ANT FRONTAL SINUS WALL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
21141	RCNSTJ MIDFACE LEFORT I 1 PIECE W O BONE GRAFT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
21142	RCNSTN MIDFACE LEFORT I 2 PIECES W O BONE GRAFT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
21143	RCNSTN MIDFACE LEFORT I 3 OR GRT PIECE W O BONE GRAFT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
21145	RCNSTJ MIDFACE LEFORT I 1 PIECE W BONE GRAFTS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
21146	RCNSTJ MIDFACE LEFORT I 2 PIECES W BONE GRAFTS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
21147	RCNSTJ MIDFACE LEFORT I 3 OR GRT PIECE W BONE GRAFTS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
21150	RCNSTJ MIDFACE LEFORT II ANTERIOR INTRUSION	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
21151	RCNSTJ MIDFACE LEFORT II W BONE GRAFTS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
21154	RCNSTJ MIDFACE LEFORT III W O LEFORT I	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
21155	RCNSTJ MIDFACE LEFORT III W LEFORT I	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
21159	RCNSTJ MIDFACE LEFORT III W FHD W O LEFORT I	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
21160	RCNSTJ MIDFACE LEFORT III W FHD W LEFORT I	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
21172	RCNSTJ SUPERIOR-LATERAL ORBITAL RIM AND LOWER FHD	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
21175	RCNSTJ BIFRONTAL SUPERIOR-LAT ORB RIMS AND LWR FHD	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
21240	ARTHRP TEMPOROMANDIBULAR JOINT W WO AUTOGRAFT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
21242	ARTHROPLASTY TEMPOROMANDIBULAR JT W ALLOGRAFT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
21243	ARTHRP TMPRMAND JOINT W PROSTHETIC REPLACEMENT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
21270	MALAR AUGMENTATION PROSTHETIC MATERIAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
21280	MEDIAL CANTHOPEXY SEPARATE PROCEDURE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
21282	LATERAL CANTHOPEXY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
21295	REDUCTION MASSETER MUSCLE AND BONE EXTRAORAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
21296	REDUCTION MASSETER MUSCLE AND BONE INTRAORAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
21601	EXCISION OF CHEST WALL TUMOR INCLUDING RIB(S)	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
21602	EXCISION CH WAL TUM W/RIB W/O MEDSTNL LYMPHADEC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
21603	EXCISION CH WAL TUM W/RIB W/MEDSTNL LYMPHADEC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
21620	OSTECTOMY STERNUM PARTIAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
21627	STERNAL DEBRIDEMENT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
21630	RADICAL RESECTION STERNUM	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
21750	CLOSE MEDIAN STERNOTOMY SEP W/WO DEBRIDEMENT SPX	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
22100	PRTL EXC PST VRT INTRNSC B1Y LES 1 VRT SGM CRV	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22101	PRTL EXC PST VRT INTRNSC B1Y LES 1 VRT SGM THRC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22102	PRTL EXC PST VRT INTRNSC B1Y LES 1 VRT SGM LMBR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22110	PRTL EXC VRT BDY B1Y LES W O SPI CORD 1 SGM CRV	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22112	PRTL EXC VRT BDY B1Y LES W O SPI CORD 1 SGM THRC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22114	PRTL EXC VRT BDY B1Y LES W O SPI CORD 1 SGM LMBR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22206	OSTEOTOMY SPINE POSTERIOR 3 COLUMN THORACIC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22207	OSTEOTOMY SPINE POSTERIOR 3 COLUMN LUMBAR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22210	OSTEOTOMY SPINE PST PSTLAT APPR 1 VRT SGM CRV	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22212	OSTEOTOMY SPINE PST PSTLAT APPR 1 VRT SGM THRC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22214	OSTEOTOMY SPINE PST PSTLAT APPR 1 VRT SGM LMBR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22220	OSTEOTOMY SPINE W DSKC ANT APPR 1 VRT SGM CRV	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22222	OSTEOTOMY SPINE W DSKC ANT APPR 1 VRT SGM THRC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22224	OSTEOTOMY SPINE W DSKC ANT APPR 1 VRT SGM LMBR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22526	PERQ INTRDSCL ELECTROTHRM ANNULOPLASTY 1 LEVEL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22527	PERQ INTRDSCL ELECTROTHRM ANNULOPLASTY ADDL LVL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22532	ARTHRODESIS LATERAL EXTRACAVITARY THORACIC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22533	ARTHRODESIS LATERAL EXTRACAVITARY LUMBAR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22548	ARTHRD ANT TRANSORL XTRORAL C1-C2 W WO EXC ODNTD	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22551	ARTHRD ANT INTERBODY DECOMPRESS CERVICAL BELW C2	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22552	ARTHRD ANT INTERDY CERVCL BELW C2 EA ADDL NTRSPC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22554	ARTHRD ANT MIN DISCECT INTERBODY CERV BELOW C2	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22556	ARTHRD ANT MIN DISCECTOMY INTERBODY THORACIC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22558	ARTHRODESIS ANTERIOR INTERBODY LUMBAR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22586	ARTHRODESIS PRESACRAL INTRBDY W INSTRUMENT L5-S1	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22590	ARTHRODESIS POSTERIOR CRANIOCERVICAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22595	ARTHRODESIS POSTERIOR ATLAS-AXIS C1-C2	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22600	ARTHRODESIS PST PSTLAT CERVICAL BELW C2 SGM	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22610	ARTHRODESIS POSTERIOR POSTEROLATERAL THORACIC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22612	ARTHRODESIS POSTERIOR POSTEROLATERAL LUMBAR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22630	ARTHRODESIS POSTERIOR INTERBODY LUMBAR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22633	ARTHDSIS POST POSTEROLATRL POSTINTERBODY LUMBAR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22800	ARTHRODESIS POSTERIOR SPINAL DFRM UP 6 VRT SEG	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22802	ARTHRODESIS POSTERIOR SPINAL DFRM 7-12 VRT SEG	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22804	ARTHRODESIS POSTERIOR SPINAL DFRM 13 OR GRT VRT SEG	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22808	ARTHRODESIS ANTERIOR SPINAL DFRM 2-3 VRT SEG	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22810	ARTHRODESIS ANTERIOR SPINAL DFRM 4-7 VRT SEG	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22812	ARTHRODESIS ANTERIOR SPINAL DFRM 8 OR GRT VRT SEG	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22818	KYPHECTOMY SINGLE OR TWO SEGMENTS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22819	KYPHECTOMY 3 OR MORE SEGMENTS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22849	REINSERTION SPINAL FIXATION DEVICE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22850	REMOVAL POSTERIOR NONSEGMENTAL INSTRUMENTATION	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22852	REMOVAL POSTERIOR SEGMENTAL INSTRUMENTATION	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22855	REMOVAL ANTERIOR INSTRUMENTATION	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22856	TOT DISC ARTHRP ART DISC ANT APPRO 1 NTRSPC CRV	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22857	TOT DISC ARTHRP ART DISC ANT APPRO 1 NTRSPC LMBR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22860	TTL DISC ARTHRPLSTY (ARTFCL DISC), ANTRR APPRCH, INCLDNG DISCECTMY TO PRPRE INTRSPCE (OTHR THAN FOR DCMPRSSION); SCND INTRSPCE, LMBR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22861	REVJ RPLCMT DISC ARTHROPLASTY ANT 1 NTRSPC CRV	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22862	REVJ RPLCMT DISC ARTHROPLASTY ANT 1 NTRSPC LMBR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22864	RMVL DISC ARTHROPLASTY ANT 1 INTERSPACE CERVICAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22865	RMVL DISC ARTHRP ANT 1 INTERSPACE LUMBAR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22867	INSJ STABLJ DEV W DCMPRN LUMBAR SINGLE LEVEL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22868	INSJ STABLJ DEV W DCMPRN LUMBAR SECOND LEVEL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22869	INSJ STABLJ DEV W O DCMPRN LUMBAR SINGLE LEVEL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
22870	INSJ STABLJ DEV W O DCMPRN LUMBAR SECOND LEVEL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
23410	OPEN REPAIR OF ROTATOR CUFF ACUTE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
23412	OPEN REPAIR OF ROTATOR CUFF CHRONIC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
23415	CORACOACROMIAL LIGAMENT RELEAS W/WOACROMIOPLASTY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
23420	RECONSTRUCTION ROTATOR CUFF AVULSION CHRONIC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
23430	TENODESIS LONG TENDON BICEPS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
23450	CAPSULORRHAPHY ANTERIOR PUTTI-PLATT/MAGNUSON	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
23455	CAPSULORRHAPHY ANTERIOR W/LABRAL REPAIR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
23460	CAPSULORRHAPHY ANTERIOR WITH BONE BLOCK	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
23462	CAPSULORRHAPHY ANTERIOR W/CORACOID PROCESS TR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
23465	CAPSULORRHAPHY GLENOHUMERAL JT PST W/WO BONE BLK	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
23466	CAPSULORRHAPHY GLENOHUMRL JT MULTI-DIRIONAL INS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
23470	ARTHROPLASTY GLENOHUMRL JT HEMIARTHROPLASTY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
23472	ARTHROPLASTY GLENOHUMERAL JOINT TOTAL SHOULDER	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
23473	REVIS SHOULDER ARTHRPLSTY HUMERAL/GLENOID COMPNT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
23474	REVIS SHOULDER ARTHRPLSTY HUMERAL AND GLENOID COMPNT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
27120	ACETABULOPLASTY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
27125	HEMIARTHROPLASTY HIP PARTIAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
27130	ARTHRP ACETBLR PROX FEM PROSTC AGRFT ALGRFT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
27132	CONV PREV HIP TOT HIP ARTHRP W WO AGRFT ALGRFT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
27134	REVJ TOT HIP ARTHRP BTH W WO AGRFT ALGRFT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
27137	REVN TOT HIP ARTHRP ACTBLR W WO AGRFT ALGRFT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
27138	REVJ TOT HIP ARTHRP FEM ONLY W WO ALGRFT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
27332	ARTHRT W/EXC SEMILUNAR CRTLG KNEE MEDIAL/LAT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
27333	ARTHRT W/EXC SEMILUNAR CRTLG KNEE MEDIAL AND LAT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
27405	RPR PRIMARY TORN LIGM AND /CAPSULE KNEE COLLATERAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
27407	REPAIR PRIMARY TORN LIGM AND /CAPSULE KNEE CRUCIAT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
27409	RPR 1 TORN LIGM AND /CAPSL KNE COLTRL AND CRUCIATE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
27418	ANTERIOR TIBIAL TUBERCLEPLASTY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
27420	RCNSTN DISLOCATING PATELLA	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
27422	RCNSTN DISLC PATELLA W/XTNSR RELIGNMT AND /MUSC RL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
27424	RCNSTJ DISLC PATELLA W/PATELLECTOMY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
27427	LIGAMENTOUS RECONSTRUCTION KNEE EXTRA-ARTICULAR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
27428	LIGAMENTOUS RECONSTRUCTION KNEE INTRA-ARTICULAR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
27429	LIGMOUS RCNSTJ AGMNTJ KNE INTRA-ARTICULAR XTR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
27438	ARTHROPLASTY PATELLA W PROSTHESIS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
27440	ARTHROPLASTY KNEE TIBIAL PLATEAU	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
27441	ARTHRP KNEE TIBIAL PLATEAU DBRDMT AND PRTL SYNVCT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
27442	ARTHROPLASTY FEM CONDYLES TIBIAL PLATEAU KNEE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
27443	ARTHRP FEM CONDYLES TIBL PLATU KNE DBRDMT AND PRTL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
27445	ARTHROPLASTY KNEE HINGE PROSTHESIS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
27446	ARTHRP KNEE CONDYLE AND PLATEAU MEDIAL LAT CMPRT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
27447	ARTHRP KNE CONDYLE AND PLATU MEDIAL AND LAT COMPARTMENTS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
27486	REVJ TOTAL KNEE ARTHRP W WO ALGRFT 1 COMPONENT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
27487	REVJ TOT KNEE ARTHRP FEM AND ENTIRE TIBIAL COMPONE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
27600	DCMPRSN FSCTMY LEG ANT AND /LAT COMPARTMENTS ONLY	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send	Y	
27601	DCMPRSN FSCTMY LEG POST COMPARTMENT ONLY	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
27602	DCMPRSN FSCTMY LEG ANT AND /LAT AND PST CMPRT	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
27603	INCISION & DRAINAGE LEG/ANKLE ABSCESS/HEMATOMA	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
28035	RELEASE TARSAL TUNNEL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28060	FASCIECTOMY PLANTAR FASCIA PARTIAL SPX	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28062	FASCIOTOMY PLANTAR FASCIA RADICAL SPX	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28080	EXCISION INTERDIGITAL MORTON NEUROMA SINGLE EACH	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28090	EXC LESION TENDON SHEATH/CAPSULE W/SYNVCT FOOT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28092	EXC LESION TENDON SHEATH/CAPSULE W/SYNVCT TOE EA	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28104	EXC/CURTG BONE CYST/B9 TUMORTARSAL/METATARSAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28108	EXC CURTG CST B9 TUM PHALANGES FOOT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28110	OSTECTOMY PRTL 5TH METAR HEAD SPX	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28111	OSTECTOMY COMPLETE 1ST METATARSAL HEAD	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28112	OSTECTOMY COMPLETE OTHER METATARSAL HEAD 2 3 4	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28113	OSTECTOMY COMPLETE 5TH METATARSAL HEAD	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28118	OSTECTOMY CALCANEUS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28119	OSTECTOMY CALCANEUS SPUR W WO PLNTAR FASCIAL RLS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28120	PARTIAL EXCISION BONE TALUS CALCANEUS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28122	PRTL EXC B1 TARSAL METAR B1 XCP TALUS CALCANEUS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28124	PARTIAL EXCISION BONE PHALANX TOE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28200	RPR TDN FLXR FOOT 1 2 W O FREE GRAFG EACH TENDON	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28202	RPR TENDON FLXR FOOT SEC W FREE GRAFT EA TENDON	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28208	REPAIR TENDON EXTENSOR FOOT 1 2 EACH TENDON	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28210	RPR TENDON XTNSR FOOT SEC W FREE GRAFT EA TENDON	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28270	CAPSUL MTTARPHLNGL JT W WO TENORRHAPHY EA JT SPX	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28285	CORRECTION HAMMERTOE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28286	CORRECTION COCK-UP 5TH TOE W PLASTIC CLOSURE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28288	OSTC PRTL EXOSTC CONDYLC METAR HEAD	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28289	HALLUX RIGIDUS W CHEILECTOMY 1ST MP JT W O IMPLT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28291	HALLUX RIGIDUS W CHEILECTOMY 1ST MP JT W IMPLT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28292	CORRJ HALLUX VALGUS W/SESMDC W/RESCJ PROX PHAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28295	CORRJ HALLUX VALGUS W SESMDC W PROX METAR OSTEOT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28296	CORRJ HALLUX VALGUS W SESMDC W DIST METAR OSTEOT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28297	CORRJ HALLUX VALGUS W SESMDC W 1METAR MEDIAL CNF	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28298	CORRJ HALLUX VALGUS W SESMDC W PROX PHLNX OSTEOT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28299	CORRJ HALLUX VALGUS W SESMDC W 2 OSTEOT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28300	OSTEOTOMY CALCANEUS W WO INTERNAL FIXATION	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28304	OSTEOTOMY TARSAL BONES OTH/THN CALCANEUS/TALUS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28305	OSTEOT TARSAL OTH THN CALCANEUS TALUS W AGRFT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28306	OSTEOT W/WO LNGTH SHRT/CORRJ 1ST METAR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28307	OSTEOT W WO LNGTH SHRT CORRJ METAR XCP 1ST TOE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28308	OSTEOT W/WO LNGTH SHRT/CORRJ METAR XCP 1ST EA	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28309	OSTEOT W WO LNGTH SHRT ANGULAR CORRJ METAR MLT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28310	OSTEOT SHRT CORRJ PROX PHALANX 1ST TOE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28312	OSTEOT SHRT CORRJ OTH PHALANGES ANY TOE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28313	RCNSTJ ANGULAR DFRM TOE SOFT TISS PX ONLY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28315	SESAMOIDECTOMY FIRST TOE SPX	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28320	REPAIR NONUNION MALUNION TARSAL BONES	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28322	RPR NON MALUNION METARSAL W WO BONE GRAFT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28344	RECONSTRUCTION TOE POLYDACTYLY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28345	RCNSTJ TOE SYNDACTYLY W WO SKIN GRAFT EACH WEB	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28705	ARTHRODESIS PANTALAR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28715	ARTHRODESIS TRIPLE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28725	ARTHRODESIS SUBTALAR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28730	ARTHRD MIDTARSL TARSOMETATARSAL MULT TRANSVRS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28735	ARTHRD MIDTARSL TARS MLT TRANSVRS W OSTEOT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28737	ARTHRD W TDN LNGTH AND ADVMNT TARSL NVCLR-CUNEIFOR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28740	ARTHRODESIS MIDTARSOMETATARSAL SINGLE JOINT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28750	ARTHRODESIS GREAT TOE METATARSOPHALANGEAL JOINT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28755	ARTHRODESIS GREAT TOE INTERPHALANGEAL JOINT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28760	ARTHRD W XTNSR HALLUCIS LONGUS TR 1ST METAR NCK	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
28890	ESWT HI NRG PHYS QHP W US GDN INVG PLNTAR FASCIA	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29805	ARTHROSCOPY SHOULDER DX W/WO SYNOVIAL BIOPSY SPX	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29806	ARTHROSCOPY SHOULDER SURGICAL CAPSULORRHAPHY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29807	ARTHROSCOPY SHOULDER SURGICAL REPAIR SLAP LESION	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29819	ARTHROSCOPY SHOULDER SURGICAL REMOVAL LOOSE FB	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29820	ARTHROSCOPY SHOULDER SURG SYNOVECTOMY PARTIAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29821	ARTHROSCOPY SHOULDER SURG SYNOVECTOMY COMPLETE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29822	ARTHROSCOPY SHOULDER SURG DEBRIDEMENT LIMITED	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29823	ARTHROSCOPY SHOULDER SURG DEBRIDEMENT EXTENSIVE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29824	ARTHROSCOPY SHOULDER DISTAL CLAVICULECTOMY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29825	ARTHROSCOPY SHOULDER AHESIOLYSIS W WO MANIPJ	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29827	ARTHROSCOPY SHOULDER ROTATOR CUFF REPAIR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29828	ARTHROSCOPY SHOULDER BICEPS TENODESIS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29860	ARTHROSCOPY HIP DIAGNOSTIC W/WO SYNOVIAL BYP SPX	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29862	ARTHRS HIP DEBRIDEMENT/SHAVING ARTICULAR CRTLG	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29863	ARTHROSCOPY HIP SURGICAL W/SYNOVECTOMY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29866	ARTHROSCOPY KNEE OSTEOCHONDRAL AGRFT MOSAICPLAST	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29867	ARTHROSCOPY KNEE OSTEOCHONDRAL ALLOGRAFT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29868	ARTHROSCOPY KNEE MENISCAL TRNSPLJ MED/LAT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29870	ARTHROSCOPY KNEE DIAGNOSTIC W/WO SYNOVIAL BX SPX	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29873	ARTHROSCOPY KNEE LATERAL RELEASE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29874	ARTHROSCOPY KNEE REMOVAL LOOSE FOREIGN BODY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29875	ARTHROSCOPY KNEE SYNOVECTOMY LIMITED SPX	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29876	ARTHROSCOPY KNEE SYNOVECTOMY 2 OR GRT COMPARTMENTS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29877	ARTHRS KNEE DEBRIDEMENT SHAVING ARTCLR CRTLG	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29879	ARTHRS KNEE ABRASION ARTHRP MLT DRLG MICROFX	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29880	ARTHRS KNEE W MENISCECTOMY MED AND LAT W SHAVING	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29881	ARTHRS KNE SURG W MENISCECTOMY MED LAT W SHVG	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29882	ARTHROSCOPY KNEE W MENISCUS RPR MEDIAL LATERAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29883	ARTHROSCOPY KNEE W MENISCUS RPR MEDIAL AND LATERAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29884	ARTHROSCOPY KNEE W LYSIS ADHESIONS W WO MANJ SPX	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29885	ARTHRS KNEE DRILL OSTEOCHONDRITIS DISSECANS GRFG	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29886	ARTHRS KNEE DRILLING OSTEOCHOND DISSECANS LESION	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29887	ARTHRS KNEE DRLG OSTEOCHOND DISSECANS INT FIXJ	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29888	ARTHRS AIDED ANT CRUCIATE LIGM RPR AGMNTJ RCNSTJ	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29889	ARTHRS AIDED PST CRUCIATE LIGM RPR AGMNTJ RCNSTJ	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29891	ARTHRS ANKLE EXC OSTCHNDRL DFCT W DRLG DFCT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				

29892	ARTHRS AID RPR LES TALAR DOME FX TIBL PLAFOND FX	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29893	ENDOSCOPIC PLANTAR FASCIOTOMY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29894	ARTHROSCOPY ANKLE W REMOVAL LOOSE FOREIGN BODY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29895	ARTHROSCOPY ANKLE SURGICAL SYNOVECTOMY PARTIAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29897	ARTHROSCOPY ANKLE SURGICAL DEBRIDEMENT LIMITED	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29898	ARTHROSCOPY ANKLE SURGICAL DEBRIDEMENT EXTENSIVE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29899	ARTHROSCOPY ANKLE SURGICAL W ANKLE ARTHRODESIS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29914	ARTHROSCOPY HIP W FEMOROPLASTY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29915	ARTHROSCOPY HIP W ACETABULOPLASTY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
29916	ARTHROSCOPY HIP W LABRAL REPAIR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
30465	REPAIR NASAL VESTIBULAR STENOSIS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
30469	RPR OF NSL VLVE CLLPSE WITH LOW ENRGY, TMPRTURE-CNTRLLD (IE, RDFRQNCY) SBCTNEOUS/SUBMCSL RMDLNG	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
30520	SEPTOPLASTY SUBMUCOUS RESECJ W WO CARTILAGE GRF	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
30545	REPAIR CHOANAL ATRESIA TRANSPALATINE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
31253	NASAL SINUS NDSC TOT W FRNT SINS EXPL TISS RMVL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
31257	NASAL SINUS NDSC TOTAL WITH SPHENOIDOTOMY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
31259	NASAL SINUS NDSC TOT W SPHENDT W SPHEN TISS RMVL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
31295	NASAL SINUS NDSC SURG W DILAT MAXILLARY SINUS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
31296	NASAL SINUS NDSC SURG W DILATION FRONTAL SINUS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
31297	NASAL SINUS NDSC SURG W DILATION SPHENOID SINUS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
31298	NASAL SINUS NDSC W FRONTAL AND SPHEN SINS DILATION	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
31660	BRONCHOSCOPIC THERMOPLASTY ONE LOBE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
31661	BRONCHOSCOPIC THERMOPLASTY 2 OR GRT LOBES	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
32035	THORACOSTOMY W/RIB RESECTION EMPYEMA	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32036	THORACOSTOMY OPEN FLAP DRAINAGE EMPYEMA	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32096	THORACTOMY W/DX BX LUNG INFILTRATE UNILATERAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32097	THORACTOMY W/DX BX LUNG NODULE/MASS UNILATERAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32098	THORACOTOMY W/BIOPSY OF PLEURA	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32100	THORACOTOMY WITH EXPLORATION	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32110	THORCOM CTRL TRAUMTC HEMRRG AND /RPR LNG TEAR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32120	THORACOTOMY POSTOPERATIVE COMPLICATIONS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32124	THORACOTOMY OPN INTRAPLEURAL PNEUMONOLYSIS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32140	THORCOM W/REMOVAL OF CYST	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32141	THORACOTOMY W/RESECTION BULLAE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32150	THORCOM W/RMVL INTRAPLEURAL FB/FIBRIN DEP	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32151	THORCOM W/RMVL IPUL FB	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32160	THORACOTOMY W/CARDIAC MASSAGE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32200	PNEUMONOSTOMY W/OPEN DRAINAGE ABSCESS/CYST	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32215	PLEURAL SCARIFICATION REPEAT PNEUMOTHORAX	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32220	DECORTICATION PULMONARY TOTAL SEPARATE PROCEDURE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32225	DECORTICATION PULMONARY PARTIAL SEPARATE PROC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32440	REMOVAL OF LUNG PNEUMONECTOMY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32442	REMOVAL LUNG PNEUMONECTOMY RESXN SGMNT TRACHEA	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32445	REMOVAL LUNG PNEUMONECTOMY EXTRAPLEURAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32480	RMVL LUNG OTHER THAN PNEUMONECTOMY 1 LOBE LOBECT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32482	RMVL LUNG OTHER THAN PNEUMONECT 2 LOBES BILOBEC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32484	RMVL LUNG OTHER THAN PNEUMONECT 1 SEGMENTECTOMY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32486	RMVL LUNG XCP TOT PNEUMONECTOMY SLEEVE LOBECTOMY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32488	RMVL LUNG OTHER/THAN PNUMEC COMPLETION PNUMEC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32491	RMVL LUNG OTH/THN PNUMEC RESXN-PLCTJ EMPHY LUNG	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32501	RESCJ AND BRONCHOPLASTY PFRMD TM LOBEC/SGMECTOMY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32503	RESCJ APICAL LUNG TUMOR W/O CHEST WALL RCNSTJ	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32504	RESCJ APICAL LUNG TUMOR W/CHEST WALL RCNSTJ	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32505	THORACOTOMY W/THERAPEUTIC WEDGE RESEXN INITIAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32506	THORACOTOMY W/THERAP WEDGE RESEXN ADDL IPSILATRL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32507	THORACOTOMY W/DX WEDGE RESEXN AND ANTOM LUNG RESE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32540	EXTRAPLEURAL ENUCLEATION EMPYEMA EMPYEMECTOMY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32601	THORSC DX LUNGS/PERICAR/MED/PLEURAL SPACE W/O BX	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
32604	THORACOSCOPY DX PERICARDIAL SAC W/BIOPSY SPX	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
32606	THORACOSCOPY DX MEDIASTINAL SPACE W/BIOPSY SPX	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
32607	THORACOSCOPY W/DX BX OF LUNG INFILTRATE UNILATRL	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
32608	THORACOSCOPY W/DX BX OF LUNG NODULES UNILATRL	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
32609	THORACOSCOPY WITH BIOPSYIES OF PLEURA	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
32650	THORACOSCOPY W/PLEURODESIS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32651	THORACOSCOPY W/PARTIAL PULMONARY DECORTICATION	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32652	THRSC TOT PULM DCRTCTJ INTRAPLEURAL PNEUMONOLSS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32653	THORACOSCOPY RMVL INTRAPLEURAL FB/FIBRIN DEPOSIT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32654	THORACOSCOPY CONTROL TRAUMATIC HEMORRHAGE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32655	THORACOSCOPY W/RESECTION BULLAE W/WO PLEURAL PX	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32656	THORACOSCOPY W/PARIETAL PLEURECTOMY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32658	THORACOSCOPY W/RMVL CLOT/FB FROM PERICARDIAL SAC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32659	THRSC CRTJ PRCRD WINDOW/PRTL RESCJ PRCRD SAC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32661	THORACOSCOPY W/EXC PERICARDIAL CYST TUMOR/MASS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32662	THORACOSCOPY W/EXC MEDIASTINAL CYST TUMOR/MASS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32663	THORACOSCOPY W/LOBECTOMY SINGLE LOBE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32664	THORACOSCOPY W/THORACIC SYMPATHECTOMY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32665	THORACOSCOPY W/ESOPHAGOMYOTOMY HELLER TYPE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32666	THORACOSCOPY W/THERA WEDGE RESEXN INITIAL UNILAT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32667	THORACOSCOPY W/THERA WEDGE RESEXN ADDL IPSILATRL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32668	THORACOSCOPY W/DX WEDGE RESEXN ANATO LUNG RESEXN	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32669	THORACOSCOPY W/SEGMENTECTOMY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32670	THORACOSCOPY W/BILOBECTOMY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32671	THORACOSCOPY W/PNEUMONECTOMY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32672	THORACOSCOPY W/RESEXN-PLICAJ EMPHYSEMA LUNG UNIL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32673	THORACOSCOPY RESEXN THYMUS UNI/BILATERAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32674	THORCOSCPY W/MEDIASTINL AND REGIONL LYMPHDENECTOMY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32800	REPAIR LUNG HERNIA THROUGH CHEST WALL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32810	CLSR CH WALL FLWG OPN FLAP DRG EMPYEMA	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32815	OPEN CLOSURE MAJOR BRONCHIAL FISTULA	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32820	MAJOR RECONSTRUCTION CHEST WALL POSTTRAUMATIC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32900	RESECTION RIBS EXTRAPLEURAL ALL STAGES	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32905	THORACOPLASTY SCHEDE TYPE/EXTRAPLEURAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32906	THORACOP SCHEDE TYP/XTRPLEURAL CLSR BRNCPLR FSTL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32940	PNEUMONOLYSIS XTRPRIOSTEAL W/FILLING/PACKING PX	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32960	PNEUMOTHORAX THER INTRAPLEURAL INJECTION AIR	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
32997	TOTAL LUNG LAVAGE UNILATERAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
32998	ABLATION PULMONARY TUMOR PERQ RADIOFREQUENCY UNI	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33016	PERICARDIOCENTESIS W/IMG GUIDANCE WHEN PERFORMED	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33017	PERQ PRCRD DRG 6YR PLUS W/O CONGENITAL CAR ANOMALY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33018	PERQ PRCRD DRG 0-5YR/ANY AGE W/CGEN CAR ANOMALY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33019	PERQ PERICARDIAL DRG W/INSJ NDWELLG CATH W/CT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33020	PERICARDIOTOMY REMOVAL CLOT/FOREIGN BODY PRIMARY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33025	CRTJ PERICARDIAL WINDOW/PRTL RESECJ W/DRG/BX	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33030	PRICARDIECTOMY STOT/COMPL W/O CARDPULM BYPASS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33031	PRICARDIECTOMY STOT/COMPL W/CARDPULM BYPASS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33050	RESECTION PERICARDIAL CYST/TUMOR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33120	EXC INTRACARDIAC TUMOR RESCJ CARDIOPULMONARY BYP	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33130	RESECTION EXTERNAL CARDIAC TUMOR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33140	TRANSMYOCARDIAL LASER REVASCULAR THORACOTOMY SPX	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33141	TRANSMYOCRD LASER REVSC PFRMD TM OTH OPN CAR PX	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33202	INSERTION EPICARDIAL ELECTRODE OPEN	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33203	INSERTION EPICARDIAL ELECTRODE ENDOSCOPIC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33206	INS NEW/RPLCMT PRM PACEMAKR W/TRANS ELTRD ATRIAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33207	INS NEW/RPLC PRM PACEMAKER W/TRANSV ELTRD VENTR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33208	INS NEW RPLCMT PRM PM W TRANSV ELTRD ATRIAL & VENT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33210	INSJ/RPLCMT TEMP TRANSVNS 1CHMBR ELTRD/PM CATH	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33211	INSJ/RPLCMT TEMP TRANSVNS 2CHMBR PACG ELTRDS SPX	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33212	INS PM PLS GEN W/EXIST SINGLE LEAD	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33213	INS PACEMAKER PULSE GEN ONLY W/EXIST DUAL LEADS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33214	UPG PACEMAKER SYS CONVERT 1CHMBR SYS 2CHMBR SYS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33215	RPSG PREV IMPLTED PM/DFB R ATR/R VENTR ELECTRODE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33216	INSJ 1 TRANSVNS ELTRD PERM PACEMAKER/IMPLTBL DFB	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33217	INSJ 2 TRANSVNS ELTRD PERM PACEMAKER/IMPLTBL DFB	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33218	RPR 1 TRANSVNS ELTRD PRM PM/PACING IMPLNTBL DFB	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
33220	RPR 2 TRANSVNS ELECTRODES PRM PM/IMPLANTABLE DFB	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
33221	INS PACEMAKER PULSE GEN ONLY W/EXIST MULT LEADS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33222	RELOCATION OF SKIN POCKET FOR PACEMAKER	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
33223	RELOCATE SKIN POCKET IMPLANTABLE DEFIBRILLATOR	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
33224	INSJ ELTRD CAR VEN SYS ATTCH PREV PM/DFB PLS GEN	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33225	INSJ ELTRD CAR VEN SYS TM INSJ DFB/PM PLS GEN	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33226	RPSG PREV IMPLTED CAR VEN SYS L VENTR ELTRD	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
33227	REMVL PERM PM PLSE GEN W/REPL PLSE GEN SNGL LEAD	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33228	REMVL PERM PM PLS GEN W/REPL PLSE GEN 2 LEAD SYS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33229	REMVL PERM PM PLS GEN W/REPL PLSE GEN MULT LEAD	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33230	INSJ IMPLNTBL DEFIB PULSE GEN W EXIST DUAL LEADS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33231	INSJ IMPLNTBL DEFIB PULSE GEN W/EXIST MULTLEADS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33233	REMOVAL PERMANENT PACEMAKER PULSE GENERATOR ONLY	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
33234	RMVL TRANSVNS PM ELTRD 1 LEAD SYS ATR/VENTR	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
33235	RMVL TRANSVNS PM ELTRD DUAL LEAD SYS	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
33236	RMVL PRM EPICAR PM AND ELTRDS THORCOM 1 LEAD SYS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33237	RMVL PRM EPICAR PM AND ELTRDS THORCOM DUAL LEAD SY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33238	RMVL PRM TRANSVENOUS ELECTRODE THORACOTOMY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33240	INSJ IMPLNTBL DEFIB PULSE GEN W/1 EXISTING LD	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33241	REMOVAL IMPLANTABLE DEFIB PULSE GENERATOR ONLY	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
33243	RMVL 1/DUAL CHAMBER DEFIB ELECTRODE BY THORACOM	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33244	RMVL1/DUAL CHMBR IMPLTBL DFB ELTRD TRANSVNS XTRJ	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
33249	INSJ/RPLCMT PERM DFB W/TRNSVNS LDS 1/DUAL CHMBR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33250	ABLATION ARRHYTHMOGENIC FOCI/PATHWAY W/O BYPASS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33251	ABLATION ARRHYTHMOGENIC FOCI/PATHWAY W/BYPASS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33254	ABLATION AND RECONSTRUCTION ATRIA LIMITED	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33255	ABLATION AND RCNSTJ ATRIA EXTNSV W/O BYPASS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33256	ABLATION AND RCNSTJ ATRIA EXTNSV W/BYPASS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33257	ATRIA ABLATE AND RCNSTJ W/OTHER PROCEDURE LIMITE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33258	ATRIA ABLTJ AND RCNSTJ W/OTHER PX EXTENSIV W/O BYP	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33259	ATRIA ABLTJ AND RCNSTJ W/OTHER PX EXTEN W/BYPASS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33261	OPRATIVE ABLTJ VENTR ARRHYTHMOGENIC FOC W/BYPASS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33262	RMVL IMPLTBL DFB PLSE GEN W/REPL PLSE GEN 1 LEAD	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33263	RMVL IMPLTBL DFB PLSE GEN W/RPLCMT PLSE GEN 2 LD	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33264	RMVL IMPLTBL DFB PLS GEN W/RPLCMT PLS GEN MLT LD	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33265	NDSC ABLATION AND RCNSTJ ATRIA LIMITED W/O BYPAS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33266	NDSC ABLATION AND RCNSTJ ATRIA EXTEN W/O BYPASS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33267	EXCLUSION LEFT ATRIAL APPENDAGE OPEN ANY METHOD	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33268	EXCLUSION LAA OPEN TM STRNT/THRCM ANY METHOD	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33269	EXCLUSION L ATR APPENDAGE THORACOSCOPIC ANY METH	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33270	INS/RPLCMNT PERM SUBQ IMPLTBL DFB W/SUBQ ELTRD	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33271	INSJ OF SUBQ IMPLANTABLE DEFIBRILLATOR ELECTRODE	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
33272	RMVL OF SUBQ IMPLANTABLE DEFIBRILLATOR ELECTRODE	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
33273	REPOS PREVIOUSLY IMPLANTED SUBQ IMPLANTABLE DFB	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
33274	TCAT INSJ/RPL PERM LEADLESS PACEMAKER RV W/IMG	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33275	TCAT REMOVAL PERM LEADLESS PACEMAKER R VENTR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33285	INSERTION SUBQ CARDIAC RHYTHM MONITOR W/PRGRMG	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33286	REMOVAL SUBCUTANEOUS CARDIAC RHYTHM MONITOR	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
33289	TCAT IMPL WRLS P-ART PRS SNR L-T HEMODYN MNTR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33300	REPAIR CARDIAC WOUND W/O BYPASS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33305	REPAIR CARDIAC WOUND W/CARDIOPULMONARY BYPASS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33310	CARDIOT EXPL W/RMVL FB ATR/VENTR THRMB W/O BYP	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33315	CARDIOT EXPL RMVL FB ATR/VENTR THRMB CARD BYP	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33320	SUTR RPR AORTA/GRT VSL W/O SHUNT/CARD BYP	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33321	SUTR RPR AORTA/GREAT VESSEL W/SHUNT BYPASS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33322	SUTURE REPAIR AORTA/GREAT VESSEL W/BYPASS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33330	INSJ GRAFT AORTA/GREAT VESSEL W/O SHUNT/BYPASS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33335	INSJ GRAFT AORTA/GREAT VESSEL W/BYPASS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33340	PERQ CLSR TCAT L ATR APNDGE W/ENDOCARDIAL IMPLNT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33361	REPLACE AORTIC VALVE PERQ FEMORAL ARTERY APPROACH	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33362	REPLACE AORTIC VALVE OPENFEMORAL ARTERY APPROACH	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33363	REPLACE AORTIC VALVE OPEN AXILLRY ARTRY APPROACH	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33364	REPLACE AORTIC VALVE OPEN ILIAC ARTERY APPROACH	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	

33365	REPLACE AORTIC VALVE OPEN TRANSAORTIC APPROACH	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33366	TRANSCATHETER TRANSAPICAL REPLACEMNT AORTIC VALVE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33367	REPLACE AORTIC VALVE W/BYP PRQ ART/VENOUS APPRCH	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33368	REPLACE AORTIC VALVE W/BYP OPEN ART/VENOUS APRCH	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33369	REPLACE AORTA VALVE W/BYP CNTRL ART/VENOUS APRCH	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33370	TRANSCATHETER PLACEMENT AND SBSQ REMOVAL CEPD PERQ	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33390	VALVULOPLASTY AORTIC VALVE OPEN CARD BYP SIMPLE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33391	VALVULOPLASTY AORTIC VALVE OPEN CARD BYP COMPLEX	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33404	CONSTRUCTION APICAL-AORTIC CONDUIT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33405	RPLCMT PROST AORTIC VALVE OPEN XCP HOMOGRF/STENT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33406	RPLCMT AORTIC VALVE OPN ALLOGRAFT VALVE FREEHAND	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33410	RPLCMT AORTIC VALVE OPN W/STENTLESS TISSUE VALVE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33411	RPLCMT AORTIC VALVE ANNULUS ENLGMENT NONC SINUS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33412	REPLACEMENT AORTIC VALVE KONNO PROCEDURE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33413	REPLACEMENT AORTIC AND PULMON VALVES ROSS PROCEDUR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33414	RPR VENTR O/F TRC OBSTRCJ PATCH ENLGMENT O/F TRC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33415	RESECTION/INCISION SUBVALVULAR TISSUE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33416	VENTRICULOMYOTOMY-MYECTOMY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33417	AORTOPLASTY SUPRAVALVULAR STENOSIS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33418	TCAT MITRAL VALVE REPAIR INITIAL PROSTHESIS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33419	TCAT MITRAL VALVE REPAIR ADDL PROSTHESIS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33420	VALVOTOMY MITRAL VALVE CLOSED HEART	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33422	VALVOTOMY MITRAL VALVE OPEN HEART W/BYPASS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33425	VALVULOPLASTY MITRAL VALVE W/CARDIAC BYPASS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33426	VLVP MITRAL VALVE W/CARD BYP W/PROSTC RING	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33427	VLVP MITRAL VALVE W/BYPASS RAD RCNSTJ W/WO RING	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33430	REPLACEMENT MITRAL VALVE W/CARDIOPULMONARY BYP	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33440	RPLCMT AORTIC VALVE BY TLCJ AUTOL PULM VALVE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33460	VALVECTOMY TRICUSPID VALVE W/CARDIOPULMONARY BYP	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33463	VALVULOPLASTY TRICUSPID VALVE W/O RING INSERTION	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33464	VALVULOPLASTY TRICUSPID VALVE W/RING INSERTION	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33465	REPLACEMENT TRICUSPID VALVE W/CARD BYPASS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33468	TRICUSPID VALVE RPSG AND PLCTJ EBSTEIN ANOMALY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33474	VALVOTOMY PULMONARY VALVE OPEN HEART W/BYPASS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33475	REPLACEMENT PULMONARY VALVE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33476	R VENTRIC RESCJ INFUND STEN W/WO COMMISSUROTOMY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33477	TCAT PULMONARY VALVE IMPLANTATION PRQ APPROACH	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33478	OUTFLOW TRACT AGMNTJ W/WO COMMISSUR/INFUND RESCJ	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33496	RPR NON-STRUCT PROSTC VALVE DYSFUNCTION W/BYPASS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33500	RPR CORONARY AV/ARTERIOCAR CHMBR FSTL W/BYPASS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33501	RPR CORONARY AV/ARTERIOCAR CHMBR FSTL W/O BYPASS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33502	RPR ANOM CORONARY ART PULM ART ORIGIN LIGATION	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33503	RPR ANOM CORONARY ARTERY PULM ART ORIGIN GRAFT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33504	RPR ANOM CORONARY ART PULM ART ORIGIN GRF W/BYP	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33505	RPR ANOM CORON ART W/CONSTJ INTRAPULM ART TUNNEL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33506	RPR ANOM CORONARY ART FROM PULM ART TO AORTA	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33507	RPR ANOM AORTIC ORIGIN CORONARY ART UNROOF/TLCJ	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33508	ENDSC SURG W/VIDEO-ASSISTED HARVEST VEIN CABG	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33509	ENDOSCOPIC HARVEST UXTR ARTERY 1 SEGMENT CAB PX	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33510	CORONARY ARTERY BYPASS 1 CORONARY VENOUS GRAFT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33511	CORONARY ARTERY BYPASS 2 CORONARY VENOUS GRAFTS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33512	CORONARY ARTERY BYPASS 3 CORONARY VENOUS GRAFTS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33513	CORONARY ARTERY BYPASS 4 CORONARY VENOUS GRAFTS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33514	CORONARY ARTERY BYPASS 5 CORONARY VENOUS GRAFTS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33516	CORONARY ARTERY BYPASS 6/ PLUS CORONARY VENOUS GRAFT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33517	CORONARY ARTERY BYP W/VEIN AND ARTERY GRAFT 1 VEIN	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33518	CORONARY ARTERY BYP W/VEIN AND ARTERY GRAFT 2 VEIN	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33519	CORONARY ARTERY BYP W/VEIN AND ARTERY GRAFT 3 VEIN	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33521	CORONARY ARTERY BYP W/VEIN AND ARTERY GRAFT 4 VEIN	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33522	CORONARY ARTERY BYP W/VEIN AND ARTERY GRAFT 5 VEIN	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33523	CORONARY ARTERY BYP W/VEIN AND ARTERY GRAFT 6 VEIN	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33530	ROPRTJ CAB/VALVE PX GT 1 MO AFTER ORIGINAL OPERJ	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33533	CABG W/ARTERIAL GRAFT SINGLE ARTERIAL GRAFT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33534	CABG W/ARTERIAL GRAFT TWO ARTERIAL GRAFTS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33535	CABG W/ARTERIAL GRAFT THREE ARTERIAL GRAFTS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33536	CABG W/ARTERIAL GRAFT FOUR OR GT ARTERIAL GRAFTS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33542	MYOCARDIAL RESECTION	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33545	RPR POSTINFRCJ VENTRICULAR SEPTAL DEFECT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33548	SURG VENTRICULAR RSTRJ PX W/PROSTC PATCH PFRMD	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33572	CORONARY ENDARTERCOMY OPEN ANY METHOD	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33600	CLOSURE ATRIOVENTRICULAR VALVE SUTURE/PATCH	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33602	CLOSURE SEMILUNAR VALVE AORTIC/PULM SUTURE/PATCH	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33606	ANAST PULMONARY ART AORTA DAMUS-KAYE-STANSEL PX	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33608	RPR CAR ANOMAL XCP PULM ATRESIA VENTR SEPTL DFCT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33610	RPR CAR ANOMAL SURG ENLGMENT VENTR SEPTL DFCT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33611	RPR 2 OUTLET R VNTRC W/INTRAVENTR TUNNEL RPR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33612	RPR 2 OUTLET R VNTRC RPR R VENTR O/F TRC OBSTRCJ	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33615	RPR CAR ANOMAL CLSR SEPTL DFCT SMPL FONTAN PX	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33617	RPR COMPLEX CARDIAC ANOMALY MODIFIED FONTAN PX	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33619	RPR 1 VNTRC W/O/F OBSTRCJ AND AORTIC ARCH HYPOPLAS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33620	APPLICATION RIGHT AND LEFT PULMONARY ARTERY BAND	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33621	TRANSTHORACIC CATHETER INSERTION FOR STENT PLMT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33622	RECONSTRUCTION COMPLEX CARDIAC ANOMALY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33641	RPR ATRIAL SEPTAL DFCT SECUNDUM W/BYP W/WO PATCH	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33645	DIR/PTCH CLS SINUS VENOSUS W/WO ANOM PUL VEN DRG	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33647	RPR ATRIAL AND VENTRIC SEPTAL DFCT DIR/PATCH CLS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33660	RPR INCPLT/PRTL AV CANAL W/WO AV VALVE RPR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33665	RPR INTRM/TRANSJ AV CANAL W/WO AV VALVE RPR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33670	RPR COMPL AV CANAL W/WO PROSTC VALVE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33675	CLOSURE MULTIPLE VENTRICULAR SEPTAL DEFECTS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33676	CLOSURE MULTIPLE VSD W/RESECTION	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33677	CLOSURE MULTIPLE VSD W/REMOVAL ARTERY BAND	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33681	CLSR 1 VENTRICULAR SEPTAL DEFECT W/WO PATCH	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33684	CLSR V-SEPTL DFCT W/PULM VLVT/INFUND RESCJ	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33688	CLSR V-SEPTAL DFCT W/RMVL P-ART BAND W/WO GUSSET	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33690	BANDING PULMONARY ARTERY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33692	COMPL RPR TETRALOGY FALLOT W/O PULM ATRESIA	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33694	COMPL RPR T-FALLOT W/O PULM ATRESIA TANULR PATCH	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33697	COMPL RPR T-FALLOT W/PULM ATRESIA	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33702	RPR SINUS VALSALVA FISTULA	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33710	RPR SINUS VALSALVA FISTULA W/RPR V-SEPTAL DEFECT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33720	RPR SINUS VALSALVA ANEURYSM	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33724	REPAIR ISOLATED PARTIAL PULM VENOUS RETURN	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33726	REPAIR PULMONARY VENOUS STENOSIS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33730	COMPLETE RPR ANOMALOUS PULMONARY VENOUS RETURN	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33732	RPR COR TRIATM/SUPVALVR RING RESCJ L ATRIAL MEMB	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33735	ATRIAL SEPTECTOMY/SEPTOSTOMY CLOSED HEART	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33736	ATRIAL SEPTECTOMY/SEPTOSTOMY OPEN HEART W/BYPASS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33741	TRNSCTHTR ATRIAL SPTSTMY FOR CONGENITAL CRDC ANMLS TO CREATE EFCTV ATRIAL FLOW, INCLUDING ALL IMAGING GUIDANCE BY THE PROCEDURALIST, WHEN PERFORMED, ANY METHOD	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33745	TIS CREATION BY STENT PLACEMENT FOR CONGENITAL CARDIAC ANOMALIES TO ESTABLISH EFFECTIVE INTRACARDIAC FLOW, INCLUDING ALL IMAGING GUIDANCE BY THE PROCEDURALIST, WHEN PERFORMED, LEFT AND RIGHT HEART DIAGNOSTIC CARDIAC CATH 1ST SHUNT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33746	TIS CREATION BY STENT PLACEMENT FOR CONGENITAL CARDIAC ANOMALIES TO ESTABLISH EFFECTIVE INTRACARDIAC FLOW, INCLUDING ALL IMAGING GUIDANCE BY THE PROCEDURALIST, WHEN PERFORMED, LEFT AND RIGHT HEART DIAGNOSTIC CARDIAC CATH EA ADDL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33750	SHUNT SUBCLAVIAN PULMONARY ARTERY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33755	SHUNT ASCENDING AORTA PULMONARY ARTERY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33762	SHUNT DESCENDING AORTA PULMONARY ARTERY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33764	SHUNT CENTRAL W/PROSTHETIC GRAFT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33766	SHUNT SUPERIOR VENA CAVA PULMONARY ART 1 LUNG	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33767	SHUNT SUPERIOR VENA CAVA PULM ARTERY BOTH LUNGS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33768	ANASTOMOSIS CAVOPULMARY 2ND SUPRIOR VENA CAVA	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33770	RPR TRPOS GREAT VSLS W/O ENLGMNT V-SEPTL DFCT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33771	RPR TRPOS GREAT VSLS W/ENLGMNT V-SEPTL DFCT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33774	RPR TRPOS GREAT VSLS ATRIAL BAFFLE PX W/BYPASS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33775	RPR TRPOS GREAT VSLS ATR BAFFLE W/RMVL PULM BAND	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33776	RPR TRPOS GRT VSL ATR BAFFLE W/CLSR V-SEPTL DFCT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33777	RPR TRPOS GRT VSL ATR BAFFLE W/BYP SBPULM OBSTRC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33778	RPR TRPOS GRT VESSEL AORTIC PULMONARY ART RCNSTJ	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33779	RPR TGV AORTIC PULM ART RCNSTJ W/RMVL PULM BAND	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33780	RPR TGV AORTIC P-ART RCNSTJ W/CLSR V-SEPTL DFCT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33781	RPR TGV AORTIC P-ART RCNSTJ RPR SBPULMC OBSTRCJ	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33782	A-ROOT TLCJ VSD PULM STNS RPR W/O C OST RIMPLTJ	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33783	A-ROOT TLCJ VSD PULM STNS RPR W/RIMPLTJ C OSTIA	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33786	TOTAL REPAIR TRUNCUS ARTERIOSUS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33788	REIMPLANTATION ANOMALOUS PULMONARY ARTERY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33800	AORTIC SUSPENSION TRACHEAL DECOMPRESSION SPX	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33802	DIVISION ABERRANT VESSEL VASCULAR RING	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33803	DIVISION ABERRANT VESSEL W/REANASTOMOSIS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33814	OBLTRJ AORTOPULMONARY SEPTAL DEFECT W/BYPASS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33820	REPAIR PATENT DUCTUS ARTERIOSUS LIGATION	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33824	RPR PATENT DUXUS ARTERIOSUS DIV 18 YR AND OLDER	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33840	EXC COARCJ AORTA W/WO PDA W/DIRECT ANASTOMOSIS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33845	EXCISION COARCTATION AORTA W/WO PDA W/GRAFT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33851	EXC COARCJ AORTA W/L SUBCLAV ART/PROSTC GUSSET	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33852	RPR HYPOPLSTC A-ARCH W/AGRFT/PROSTC W/O BYPASS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33853	RPR HYPOPLSTC A-ARCH W/AGRFT/PROSTC W/BYPASS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33858	AS-AORT GRF W/CARD BYP F/AORTIC DISSECTION	OP Hosp/Amb Surgery Center (ASC) procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
33859	AS-AORT GRF W/CARD BYP F/AORTIC DS OTH/THN DSJ	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
33863	AS-AORT GRF W/CARD BYP AND AORTIC ROOT RPLCMT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33864	ASCENDING AORTA GRF VALVE SPARE ROOT REMODEL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33866	AORTIC HEMIARCH GRAFT W/ISOL AND CTRL ARCH VESSELS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33871	TRANSVRS A-ARCH GRF W/CARD BYP PRFD HYPOTHERMIA	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
33875	DESCENDING THORACIC AORTA GRAFT W/WO BYPASS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33877	RPR THORACOABDOMINAL AORTIC ANEURYS W/WO BYPASS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33880	EVASC RPR DTA COVERAGE ART ORIGIN 1ST ENDOPROSTH	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33881	EVASC RPR DTA EXP COVERAGE W/O ART ORIGIN	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33883	PLMT PROX XTN PROSTH EVASC RPR DTA 1ST XTN	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33884	PLMT PROX XTN PROSTH EVASC RPR DTA EA PROX XTN	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33886	PLMT DSTL XTN PROSTH DLYD AFTER EVASC RPR DTA	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33889	OPN SUBCLA CRTD ART TRPOS NCK INC ULAT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33891	BYP GRF W/DESCENDING THORACIC AORTA RPR NECK INC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33894	EVASC ST RPR COARCJ THRC/AA ACRS MAJ SIDE BRNCH	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33895	EVASC ST RPR COARCJ THRC/AA XCRSG MAJ SIDE BRNCH	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33897	PERQ TRANSLUMINAL ANGIOPLASTY NATIVE/RECR COA	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33900	PERQ P-ART REVSC ST 1ST NML NATIVE CONNJ UNI	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33901	PERQ P-ART REVSC ST 1ST NML NATIVE CONNJ BI	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33902	PERQ P-ART REVSC ST 1ST ABNOR CONNJ UNILATERAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33903	PERQ P-ART REVSC ST 1ST ABNORMAL CONNJ BILATERAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33904	PERQ P-ART REVSC ST EA ADDL VSL/SEP LES NM/ABNL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.		
33910	PULMONARY ARTERY EMBOLECTOMY W/CARD BYPASS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33915	PULMONARY ARTERY EMBOLECTOMY W/O CARD BYPASS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33916	PULMONARY ENDARTERCOMY W/WO EMBOLECTOMY W/BYPASS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33917	RPR PULMONARY ART STENOSIS RCNSTJ W/PATCH/GRAFT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33920	RPR PULMONARY ATRESIA W/CONSTJ/RPLCMT CONDUIT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33922	TRANSECTION PULMONARY ARTERY W/CARD BYPASS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33924	LIG AND TKDN SYSIC-TO-PULM ART SHUNT W/CGEN HEART	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33925	RPR P-ART ARBORIZJ ANOMAL UNIFCLIZJ W/O BYPASS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33926	RPR P-ART ARBORIZJ ANOMAL UNIFCLIZJ W/BYPASS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
33975	INSJ VENTRIC ASSIST DEV XTRCORP SINGLE VENTRICLE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
33976	INSJ VENTRIC ASSIST DEV XTRCORP BIVENTRICULAR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
33979	INSJ VENTR ASSIST DEV IMPLTABLE ICORP 1 VNTRC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
34001	EMBLC/THRMBC CATH CRTD SUBCLA/INNOMINATE ART	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
34051	EMBLC/THRMBC INNOMINATE SUBCLAVIAN ARTERY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
34101	EMBLC/THRMBC AX BRACH INNOMINATE SUBCLA ART	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
34111	EMBLC/THRMBC W/WO CATH RADIAL/ULNAR ART ARM INC	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
34151	EMBLC/THRMBC RNL CELIAC MESENTRY AORTO-ILIAC ART	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
34201	EMBLC/THRMBC FEMORAL POPLITEAL AORTO-ILIAC ART	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
34203	EMBLC/THRMBC POPLITEAL-TIBIO-PRONEAL ART LEG INC	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	

34401	THRMBC DIR/W/CATH VENA CAVA ILIAC VEIN ABDL INC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
34421	THRMBC DIR/W/CATH V/C ILIAC FEMPOP VEIN LEG INC	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
34451	THRMBC DIR/W/CATH V/C ILIAC FEMPOP VEIN ABDL & LEG	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
34471	THRMBC DIR/W/CATH SUBCLAVIAN VEIN NECK INC	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
34490	THRMBC DIR/W/CATH AXILL&SUBCLAVIAN VEIN ARM IN	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
34501	VALVULOPLASTY FEMORAL VEIN	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
34502	RECONSTRUCTION VENA CAVA ANY METHOD	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
34510	VENOUS VALVE TRANSPOSITION ANY VEIN DONOR	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
34520	CROSS-OVER VEIN GRAFT VENOUS SYSTEM	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
34530	SAPHENOPOPLITEAL VEIN ANASTOMOSIS	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
34701	EVASC RPR DPLMNT AORTO-AORTIC NDGFT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
34702	EVASC RPR DPLMNT AORTO-AORTIC NDGFT RPT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
34703	VASC RPR DPLMNT AORTO-UNI-ILIAC NDGFT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
34704	EVASC RPR DPLMNT AORTO-UNI-ILIAC NDGFT RPT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
34705	EVASC RPR DPLMNT AORTO-BI-ILIAC NDGFT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
34706	EVASC RPR DPLMNT AORTO-BI-ILIAC NDGFT RPT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
34707	EVASC RPR DPLMNT ILIO-ILIAC NDGFT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
34708	EVASC RPR DPLMNT ILIO-ILIAC NDGFT RPT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
34709	PLACEMENT XTN PROSTH FOR ENDOVASCULAR RPR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
34710	THRMBC DIR/W/CATH AXILL AND SUBCLAVIAN VEIN ARM IN	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
34711	DLYD PLACEMENT XTN PROSTH FOR EVASC RPR EA ADDL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
34712	TRANSCATHETER DLVR ENHNCD FIXATION DEVICES RS AND I	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
34713	PERQ ACCESS AND CLOSURE FEM ART FOR DELIVERY NDGFT	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
34714	OPN FEM ART EXPOS W/CNDT CRTJ DLVR EVASC PROSTH	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
34715	OPN AX/SUBCLA ART EXPOS DLVR EVASC PROSTH UNI	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
34716	OPN AXILLARY/SUBCLAVIAN ART EXPOS W/CNDT CRTJ	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
34717	EVASC RPR ILIAC ART TM OF A-ILIAC ART NDGFT UNI	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
34718	EVASC RPR DPLMNT AORTO-UNI-ILIAC NDGFT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
34808	EVASC PLACEMENT ILIAC ARTERY OCCLUSION DEVICE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
34812	OPN FEM ART EXPOS DLVR EVASC PROSTH UNI	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
34813	PLMT FEM-FEM PROSTC GRF EVASC AORTIC ARYSM RPR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
34820	OPN ILIAC ART EXPOS PROSTH/ILIAC OCCLS EVASC UNI	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
34830	OPN RPR ARYSM RPR ARTL TRAUMA TUBE PROSTH	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
34831	OPN RPR ARYSM RPR ARTL TRMA AORTOBILIAC PROSTH	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
34832	DLYD PLACEMENT XTN PROSTH FOR EVASC RPR 1ST VSL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
34833	OPN ILIAC ART EXPOS CRTJ PROSTH EST CARD BYP	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
34834	OPN BRACHIAL ARTERY EXPOS DLVR EVASC PROSTH UNI	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
34839	PLNNING PT SPEC FENEST VISCERAL AORTIC GRAFT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
34841	ENDOVASC VISCER AORTA REPAIR FENEST 1 ENDOGRAFT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
34842	ENDOVASC VISCER AORTA REPAIR FENEST 2 ENDOGRAFT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
34843	ENDOVASC VISCER AORTA REPAIR FENEST 3 ENDOGRAFT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
34844	ENDOVASC VISCER AORTA REPR FENEST 4 PLUS ENDOGRAFT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
34845	EVASC RPR ILIAC ART N/A A-ILIAC ART NDGFT UNI	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
34846	VISCER AND INFRARENAL ABDOM AORTA 2 PROSTHESIS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
34847	VISCER AND INFRARENAL ABDOM AORTA 3 PROSTHESIS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
34848	VISCER AND INFRARENAL ABDOM AORTA 4 PLUS PROSTHESIS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35001	DIR RPR ANEURYSM CAROTID-SUBCLAVIAN ARTERY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35002	DIR RPR RUPTD ANEURYSM CAROTID-SUBCLAVIAN ARTERY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35005	DIR RPR ANEURYSM VERTEBRAL ARTERY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35011	DRCT RPAIR ANEURYSM AXIL-BRACHIAL ARM INCISION	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
35013	DIR RPR RUPTD ANEURYSM AXIL-BRACHIAL ARM INCIS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35021	DIR RPR ANEURYSM INNOMINATE/SUBCLAVIAN ARTERY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35022	DIR RPR RUPTD ANEURYSM INNOMINATE/SUBCLAVIAN	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35045	DRCT RPAIR ANEURYSM RADIAL/ULNAR ARTERY	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
35081	DIR RPR ANEURYSM ABDOMINAL AORTA	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35082	DIR RPR RUPTD ANEURYSM ABDOMINAL AORTA	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35091	DIR RPR ANEURYSM ABDOM AORTA W/VISCERAL VESSELS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35092	VISCER AND INFRARENAL ABDOM AORTA 1 PROSTHESIS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35102	DIR RPR ANEURYSM ABDOM AORTA W/ILIAC VESSELS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35103	DIR RPR RUPTD ANEURYSM ABDOM AORTA W/ILIAC VSLS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35111	DIR RPR ANEURYSM SPLENIC ARTERY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35112	DIR RPR RUPTD ANEURYSM SPLENIC ARTERY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35121	DIR RPR ANEURYSM HEPATIC/CELIAC/RENAL/MESENTERIC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35122	DIR RPR RUPTD ANEURSM HEPATIC/CELIAC/RENAL/MESEN	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35131	DIR RPR ANEURYSM AXIL-BRACHIAL ARM INCISION	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35132	DIR RPR RUPTD ANEURYSM AND GRAFT ILIAC ARTERY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35141	DIR RPR ANEURYSM AND GRAFT COMMON FEMORAL ARTERY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35142	DIR RPR RUPTD ANEURYSM AND GRF COMMON FEMORAL ART	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35151	DIR RPR RUPTD ANEURYSM RADIAL/ULNAR ARTERY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35152	DIR RPR RUPTD ANEURYSM AND GRF POPLITEAL ARTERY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35180	REPAIR CONGENITAL AV FISTULA HEAD & NECK	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
35182	RPR CONGENITAL AV FISTULA THORAX AND ABDOMEN	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
35184	RPR CONGENITAL AV FISTULA EXTREMITIES	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
35188	RPR ACQRD/TRAUMATIC AV FISTULA HEAD & NECK	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
35189	RPR/TRAUMATIC AV FISTULA THORAX & ABDOMEN	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
35190	RPR ACQRD/TRAUMATIC AV FISTULA EXTREMITIES	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
35201	REPAIR BLOOD VESSEL DIRECT NECK	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
35206	REPAIR BLOOD VESSEL DIRECT UPPER EXTREMITY	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
35207	REPAIR BLOOD VESSEL DIRECT HAND FINGER	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
35211	DIR RPR ANEURYSM AND GRAFT ILIAC ARTERY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35216	RPR BLOOD VESSEL DIRECT INTRATHORACIC W/O BYPASS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35221	RPR BLOOD VESSEL DIRECT INTRA-ABDOMINAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35226	RPR BLOOD VESSEL DIRECT LOWER EXTREMITY	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
35231	REPAIR BLOOD VESSEL W/VEIN GRAFT NECK	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
35236	REPAIR BLOOD VESSEL W/VEIN GRAFT UPPER EXTREMITY	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
35241	RPR BLOOD VESSEL VEIN GRAFT INTRATHORACIC W/BYP	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35246	RPR BLOOD VESSEL VEIN GRF INTRATHORACIC W/O BYP	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35251	REPAIR BLOOD VESSEL VEIN GRAFT INTRA-ABDOMINAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35256	REPAIR BLOOD VESSEL VEIN GRAFT LOWER EXTREMITY	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
35261	REPAIR BLOOD VESSEL W/GRAFT OTHER/THAN VEIN NECK	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
35266	RPR BLOOD VSL GRF OTH/THN VEIN UPPER EXTREMITY	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
35271	RPR BLOOD VSL GRF OTH/THN VEIN INTRATHRC W/BYP	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35276	RPR BLOOD VSL GRF OTH/THN VEIN INTRATHRC W/O BYP	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35281	RPR BLVSL W/GRFT OTHER/THAN VEIN INTRA-ABDOMINAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35286	RPR BLVSL W/GRF OTHER/THAN VEIN LOWER EXTREMITY	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
35301	TEAEC W/PATCH GRF CAROTID VERTB SUBCLAV NECK INC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35302	TEAEC W/GRAFT SUPERFICIAL FEMORAL ARTERY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35303	TEAEC W/GRAFT POPLITEAL ARTERY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35304	TEAEC W/GRAFT TIBIOPERONEAL TRUNK ARTERY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35305	TEAEC W/GRAFT TIBIAL/PERONEAL ART 1ST VESSEL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35306	TEAEC W/GRAFT EA ADDL TIBIAL/PERONEAL ART	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35311	TEAEC W/WO PATCH GRF SUBCLAV INNOM THORACIC INC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35321	TEAEC W/WO PATCH GRF AXILLARY-BRACHIAL	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
35331	TEAEC W/WO PATCH GRAFT ABDOMINAL AORTA	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35341	TEAEC W/WO PATCH GRAFT MESENTERIC CELIAC/RENAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35351	TEAEC W/WO PATCH GRAFT ILIAC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35355	TEAEC W/WO PATCH GRAFT ILIOFEMORAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35361	TEAEC W/WO PATCH GRAFT COMBINED AORTOILIAC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35363	TEAEC W/WO PATCH GRAFT COMBINED AORTOILIOFEMORAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35371	TEAEC W/WO PATCH GRAFT COMMON FEMORAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35372	TEAEC W/WO PATCH GRAFT DEEP PROFUNDA FEMORAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35390	ROPRTJ CRTD TEAEC GT 1 MO AFTER ORIGINAL OPRATJO	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35400	ANGIOSCOPY NON-CORONARY VESSEL/GRAFTS THER NNTJ	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35500	HARVEST UXTR VEIN 1 SGM LOWER EXTREMITY/CABG PX	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35501	BYPASS W/VEIN COMMON-IPSILATERAL CAROTID	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35506	BYPASS W/VEIN CAROTID-SUBCLV/SUBCLAVIAN CAROTID	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35508	BYPASS W/VEIN CAROTID-VERTEBRAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35509	BYPASS W/VEIN CAROTID-CONTRALATERAL CAROTID	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35510	BYPASS W/VEIN CAROTID-BRACHIAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35511	BYPASS W/VEIN SUBCLAVIAN-SUBCLAVIAN	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35512	BYPASS W/VEIN SUBCLAVIAN-BRACHIAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35515	BYPASS W/VEIN SUBCLAVIAN-VERTEBRAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35516	BYPASS W/VEIN SUBCLAVIAN-AXILLARY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35518	BYPASS W/VEIN AXILLARY-AXILLARY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35521	BYPASS W/VEIN AXILLARY-FEMORAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35522	BYPASS W/VEIN AXILLARY-BRACHIAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35523	BYPASS W/VEIN BRACHIAL-ULNAR/-RADIAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35525	BYPASS W/VEIN BRACHIAL-BRACHIAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35526	BYPASS W/VEIN AORTOSUBCLAV/CAROTID/INNOMINATE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35531	BYPASS W/VEIN AORTOCELIAC/AORTOMESENTERIC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35533	BYPASS W/VEIN AXILLARY-FEMORAL-FEMORAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35535	BYPASS W/VEIN HEPATORENAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35536	BYPASS W/VEIN SPLENORENAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35537	BYPASS W/VEIN AORTOILIAC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35538	BYPASS W/VEIN AORTOBI-ILIAC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35539	BYPASS W/VEIN AORTOFEMORAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35540	BYPASS W/VEIN AORTOBIFEMORAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35556	BYPASS W/VEIN FEMORAL-POPLITEAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35558	BYPASS W/VEIN FEMORAL-FEMORAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35560	BYPASS W/VEIN AORTORENAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35563	BYPASS W/VEIN ILIOILIAC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35565	BYPASS W/VEIN ILIOFEMORAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35566	BYP FEM-ANT TIBL PST TIBL PRONEAL ART/OTH DSTL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35570	BYP TIBL-TIBL/PERONEAL-TIBL/TIBL/PRONEAL TRK-TIBL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35571	BYP W/VEIN POP-TIBL-PRONEAL ART/OTH DSTL VSL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35572	HARVEST FEMPOP VEIN 1 SGM VASC RCNSTJ PX	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35583	IN-SITU VEIN BYPASS FEMORAL-POPLITEAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35585	IN-SITU FEM-ANT TIBL PST TIBL/PRONEAL ART	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35587	IN-SITU VEIN BYP POP-TIBL PRONEAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35600	OPEN HARVEST UPPER EXTREMITY ART 1 SEGMENT CAB	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35601	BYP OTH/THN VEIN COMMON-IPSILATERAL CAROTID	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35606	BYP OTH/THN VEIN CAROTID-SUBCLAVIAN	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35612	BYP OTH/THN VEIN SUBCLAVIAN-SUBCLAVIAN	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35616	BYP OTH/THN VEIN SUBCLAVIAN-AXILLARY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35621	BYP OTH/THN VEIN AXILLARY-FEMORAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35623	BYP OTH/THN VEIN AXILLARY-POPLITEAL/-TIBIAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35626	BYPASS NOT VEIN AORTOSUBCLA/CAROTID/INNOMINATE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35631	BYP OTH/THN VEIN AORTOCELIAC AORTOMSN AORTORNL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35632	BYPASS GRAFT W/OTHER THAN VEIN ILIO-CELIAC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35633	BYPASS GRAFT W/OTHER THAN VEIN ILIO-MESENTERIC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35634	BYPASS GRAFT W/OTHER THAN VEIN ILIORENAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35636	BYP OTH/THN VEIN SPLENORENAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35637	BYP OTH/THN VEIN AORTOILIAC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35638	BYP OTH/THN VEIN AORTOBI-ILIAC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35642	BYP OTH/THN VEIN CAROTID-VERTEBRAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35645	BYP OTH/THN VEIN SUBCLAVIAN-VERTEBRAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35646	BYP OTH/THN VEIN AORTOBIFEMORAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35647	BYP OTH/THN VEIN AORTOFEMORAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35650	BYP OTH/THN VEIN AXILLARY-AXILLARY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35654	BYP OTH/THN VEIN AXILLARY-FEMORAL-FEMORAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35656	BYP OTH/THN VEIN FEMORAL-POPLITEAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35661	BYP OTH/THN VEIN FEMORAL-FEMORAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35663	BYP OTH/THN VEIN ILIOILIAC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35665	BYP OTH/THN VEIN ILIOFEMORAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35666	BYP OTH/THN VEIN FEM-ANT TIBL PST TIBL/PRONEAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35671	BYP OTH/THN VEIN POPLITEAL-TIBIAL/-PERONEAL ART	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35681	BYPASS COMPOSITE GRAFT PROSTHETIC AND VEIN	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35682	BYP AUTOG COMPOSIT 2 SEG VEINS FROM 2 LOCATIONS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35683	BYP AUTOG COMPOSIT 3 OR GT SEG FROM 2 OR GT LOCATION	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35685	PLMT VEIN PATCH/CUFF DSTL ANAST BYP CONDUIT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35686	CRTJ DSTL ARVEN FSTL LXTR BYP SURG NON-HEMO	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35691	TRPOS AND /RIMPLTJ VERTEBRAL CAROTID ART	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35693	TRPOS AND /RIMPLTJ VERTEBRAL SUBCLAVIAN ART	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35694	TRPOS AND /RIMPLTJ SUBCLAVIAN CAROTID ART	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35695	TRPOS AND /RIMPLTJ CAROTID SUBCLAVIAN ART	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35697	RIMPLTJ VISC ART INFRARNL AORTIC PROSTH EA ART	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	

35700	ROPRTJ GT 1 MO AFTER ORIGINAL OPRATION	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35701	EXPLORATION N/FLWD SURG NECK ARTERY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35702	EXPLORATION N/FLWD SURG UPPER EXTREMITY ARTERY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35703	EXPLORATION N/FLWD SURG LOWER EXTREMITY ARTERY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35800	EXPL PO HEMRRG THROMBOSIS/INFCTJ NCK	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35820	EXPL PO HEMRRG THROMBOSIS/INFCTJ CH	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35840	EXPL PO HEMRRG THROMBOSIS/INFCTJ ABD	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35860	EXPL PO HEMRRG THROMBOSIS/INFCTJ XTR	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
35870	RPR GRF-ENTERIC FSTL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35875	THRMBC ARTL/VEN GRF OTH/THN HEMO GRF/FSTL	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
35876	THRMBC ARTL/VEN GRF XCP HEMO GRF/FSTL W/REVJ GRF	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
35879	REVJ LXTR ARTL BYP OPN VEIN PATCH ANGIOP	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
35881	REVJ LXTR ARTL BYP OPN W/SGMTL VEIN INTERPOS	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
35883	REVISION FEMORAL ANAST OPEN NONAUTOG GRAFT	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
35884	REVISION FEMORAL ANAST OPEN W/AUTOG GRAFT	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
35901	EXCISION INFECTED NECK GRAFT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35903	EXCISION INFECTED GRAFT EXTREMITY	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send	Y	
35905	EXCISION INFECTED GRAFT THORAX	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
35907	EXCISION INFECTED GRAFT ABDOMEN	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
36000	INTRODUCTION NEEDLE/INTRACATHETER VEIN	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
36002	INJECTION PX PRQ TX EXTREMITY PSEUDOANEURYSM	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
36005	NJX PX XTR VNGRPH W/INTRO NDL/INTRACATH	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
36010	INTRO CATHETER SUPERIOR/INFERIOR VENA CAVA	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
36011	SLCTV CATH PLMT VEN SYS 1ST ORDER BRANCH	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
36140	INTRO NEEDLE/INTRACATH UPR/LWR XTRMTY ARTRY	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
36200	INTRODUCTION CATHETER AORTA	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
36215	SLCTV CATHJ EA 1ST ORD THRC/BRCH/CPHLC BRNCH	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
36216	SLCTV CATHJ 1ST 2ND ORD THRC/BRCH/CPHLC BRNCH	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
36217	SLCTV CATHTR PLCMNT 3RD+ ORD SLCTV THRC/BRCH/CPHLC BRNCH	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
36221	NONSLCTV CATH THOR AORTA ANGIO INTR/XTRCRANL ART	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
36222	SLCTV CATH CAROTID/INNOM ART ANGIO XTRCRANL ART	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
36223	SLCTV CATH CAROTID/INNOM ART ANGIO INTRCRANL ART	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
36224	SLCTV CATH INTRNL CAROTID ART ANGIO INTRCRNL ART	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
36225	SLCTV CATH SUBCLAVIAN ART ANGIO VERTEBRAL ARTERY	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
36226	SLCTV CATH VERTEBRAL ART ANGIO VERTEBRAL ARTERY	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
36245	SLCTV CATHJ EA 1ST ORD ABDL PEL/LXTR ART BRNCH	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
36246	SLCTV CATHJ 2ND ORDER ABDL PEL/LXTR ART BRNCH	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
36247	SLCTV CATHTR PLCMNT 3RD+ ORD SLCTV ABDL PLVC LWR XTRMTY BRNCH	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
36251	SLCTV CATH 1STORD W/WO ART PUNCT/FLUORO/S&I UN	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
36252	SLCTV CATH 1STORD W/WO ART PUNCT/FLUOR/S&I BIL	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
36253	SUPSLCTV CATH 2ND PLUS ORD RENAL AND ACCESSORY ARTERY/S UNI	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
36254	SUPSLCTV CATH 2ND PLUS ORD RENAL AND ACCESSORY ARTERY/S BIL	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
36465	NJX NONCMPND SCLEROSANT SINGLE INCMPTNT VEIN	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
36466	NJX NONCMPND SCLEROSANT MULTIPLE INCMPTNT VEINS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
36468	INJECTIONS SCLEROSANT FOR SPIDER VEINS LIM TRNK	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
36470	INJXN SCLRSNT SINGLE INCMPTNT VEIN	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
36471	INJXN SCLRSNT MLTPLE INCMPTNT VEINS, SAME LEG	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
36473	ENDOVEN ABLTJ INCMPTNT VEIN MCHNCHEM 1ST VEIN	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
36474	ENDOVEN ABLTJ INCMPTNT VEIN MCHNCHEM SBSQ VEINS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
36475	ENDOVEN ABLTJ INCMPTNT VEIN XTR RF 1ST VEIN	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
36476	ENDOVEN ABLTJ INCMPTNT VEIN XTR RF 2ND PLUS VEINS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
36478	ENDOVEN ABLTJ INCMPTNT VEIN XTR LASER 1ST VEIN	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
36479	ENDOVEN ABLTJ INCMPTNT VEIN XTR LASER 2ND PLUS VEINS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
36482	ENDOVEN ABLTJ THER CHEM ADHESIVE 1ST VEIN	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
36483	ENDOVEN ABLTJ THER CHEM ADHESIVE SBSQ VEIN	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
36800	INSJ CANNULA HEMO OTH PURPOSE SPX VEIN VEIN	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
36810	INSJ CANNULA HEMO OTH PURPOSE SPX ARVEN XTRNL	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
36815	INSJ CANNULA HEMO OTH SPX ARVEN XTRNL REVJ/CLSR	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
36818	ARVEN ANAST OPN UPR ARM CEPHALIC VEIN TRPOS	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
36819	ARVEN ANAST OPN UPR ARM BASILIC VEIN TRPOS	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
36820	ARVEN ANAST OPN F/ARM VEIN TRPOS	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
36821	ARTERIOVENOUS ANASTOMOSIS OPEN DIRECT	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
36825	CRTJ ARVEN FSTL XCP DIR ARVEN ANAST AUTOG GRF	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
36830	CRTJ ARVEN FSTL XCP DIR ARVEN ANAST NONAUTOG GRF	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
36831	THRMBC OPN ARVEN FSTL W/O REVJ DIAL GRF	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
36832	REVJ OPN ARVEN FSTL W/O THRMBC DIAL GRF	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
36833	REVJ OPN ARVEN FSTL W/THRMBC DIAL GRF	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
36835	INSERTION THOMAS SHUNT SEPARATE PROCEDURE	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
36836	PERQ AV FISTULA CREATION UXTR SINGLE ACCESS	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
36837	PERQ AV FISTULA CREATION UXTR SEP ACCESS SITES	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
36838	DSTL REVSC&INTERVAL LIG UXTR HEMO ACCESS	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
36860	XTRNL CANNULA DECLTNG SPX W/O BALO CATH	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
36861	XTRNL CANNULA DECLTNG SPX W/BALO CATH	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
37184	PRIM PRQ TRLUML MCHNL THRMBC N-COR N-ICRA 1ST	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
37187	PRQ TRANSLUMINAL MECHANICAL THROMBECTOMY VEIN	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
37188	PRQ TRLUML MCHNL THRMBC VEIN REPEAT TX	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
37191	INSRTN INTRVAS VC FLTR W/ VAS ACS VSL SELXN RS AND I	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
37192	REPSNG INTRVAS VC FLTR W/WO ACS VSL SELXN RS & I	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
37193	RTRVL INTRVAS VC FLTR W/WO ACS VSL SELXN RS&I	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
37197	PRQ TRANSCATHETER RTRVL INTRVAS FB WITH IMAGING	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
37211	THROMBOLYSIS ARTERIAL INFUSION ICRA RS&I INIT TX	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
37212	THROMBOLYSIS VENOUS INFUSION W/IMAGING INIT TX	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
37213	THROMBOLYSIS ART/VENOUS INFSN W/IMAGE SUBSQ TX	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
37214	CESSATION THROMBOLYTIC THER W/CATHETER REMOVAL	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
37215	TCAT IV STENT CRV CRTD ART EMBOLIC PROTECJ	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
37216	TCAT IV STENT CRV CRTD ART W/O EMBOLIC PROTECJ	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
37217	TCATH STENT PLACEMT RETROGRAD CAROTID/INNOMINATE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
37218	TCATH STENT PLACEMT ANTEGRADE CAROTID/INNOMINATE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
37220	REVASCULARIZATION ILIAC ARTERY ANGIOP 1ST VSL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
37221	REVSC OPN/PRQ ILIAC ART W/STNT PLMT & ANGIOPLSTY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
37224	REVSC OPN/PRQ FEM/POP W/ANGIOPLASTY UNI	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
37225	REVSC OPN/PRQ FEM/POP W/ATHRC/ANGIOP SM VSL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
37226	REVSC OPN/PRQ FEM/POP W/STNT/ANGIOP SM VSL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
37227	REVSC OPN/PRQ FEM/POP W/STNT/ATHRC/ANGIOP SM VSL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
37228	REVSC OPN/PRQ TIB/PERO W/ANGIOPLASTY UNI	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
37229	REVSC OPN/PRQ TIB/PERO W/ATHRC/ANGIOP SM VSL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
37230	REVSC OPN/PRQ TIB/PERO W/STNT/ANGIOP SM VSL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
37231	REVSC OPN/PRQ TIB/PERO W/STNT/ATHR/ANGIOP SM VSL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
37236	OPEN/PERQ PLACEMENT INTRAVASCULAR STENT INITIAL	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
37238	OPEN/PERQ PLACEMENT INTRAVASCULAR STENT SAME 1ST	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
37241	VASCULAR EMBOLIZATION OR OCCLUSION VENOUS RS&I	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
37242	VASCULAR EMBOLIZATION OR OCCLUSION ARTERIAL RS&I	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
37243	VASCULAR EMBOLIZ/OCCLUDE ORGAN TUMOR INFARCT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
37244	VASCULAR EMBOLIZATION OR OCCLUSION HEMORRHAGE	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
37246	TRLML BALO ANGIOP OPEN/PERQ IMG S&I 1ST ART	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
37248	TRLML BALO ANGIOP OPEN/PERQ W/IMG S&I 1ST VEIN	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
37500	VASC ENDOSCOPY SURG W/LIG PERFORATOR VEINS SPX	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
37565	LIGATION INTERNAL JUGULAR VEIN	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
37600	LIGATION EXTERNAL CAROTID ARTERY	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
37605	LIGATION INTERNAL/COMMON CAROTID ARTERY	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
37606	LIG INT/COMMON CAROTID ART W/GRADUAL OCCLUSION	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
37607	LIG/BANDING ANGIOACCESS ARTERIOVENOUS FISTULA	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
37609	LIGATION/BIOPSY TEMPORAL ARTERY	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
37618	LIGATION MAJOR ARTERY EXTREMITY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
37619	INS INTRVAS VC FILTR W/WO VAS ACS VSL SELXN RS&I	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
37650	LIGATION OF FEMORAL VEIN	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
37660	LIGATION OF COMMON ILIAC VEIN	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
37700	LIGTN &DIVSN LONG SAPH VEIN SAPHFEM JUNCT/DISTAL INTERRUPN	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
37718	LIGTN DIVSN AND STRIPPING SHORT SAPHENOUS VEIN	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
37722	LIGTN DIVSN AND STRIPNG LONG SAPH SAPHFEM JUNCT KNE BELW	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
37735	LIGTN AND DIVN RDCL STRIPNG LONG SHORT SAPHENOUS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
37760	LIG PRFRATR VEIN SUBFSCAL RAD INCL SKN GRF 1 LEG	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
37761	LIG PRFRATR VEIN SUBFSCAL OPEN INCL US GID 1 LEG	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
37765	STAB PHLEBT VARICOSE VEINS 1 XTR 10-20 STAB INCS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
37766	STAB PHLEBT VARICOSE VEINS 1 XTR > 20 INCS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
37780	LIGTN & DIVSN SHORT SAPH VEIN SAPHENPOPLTL JUNCT SPX	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
37785	LIGTN DIVSN AND EXCSN VARICOSE VEIN CLUSTER 1 LEG	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
38746	THORCOM THRC W/MEDSTNL AND REGIONAL LMPHADEC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
39000	MEDIAST W/EXPL DRG RMVL FB/BX CRV APPR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
39010	MEDIAST W/EXPL DRG RMVL FB/BX TTHRC APPR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
39200	RESECTION OF MEDIASTINAL CYST	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
39220	RESECTION MEDIASTINAL TUMOR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
39401	MEDIASTINOSCOPY INCLUDES MEDIASTINAL MASS BIOPSY	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
39402	MEDIASTINOSCOPY WITH LYMPH NODE BIOPSY(IES)	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y*	*Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
42975	DISE DYN EVAL SLEEP DISORDERED BREATHING FLX DX	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
43291	ESPHGGSTRODUDNSCPY, FLXIBLE, TRNSORAL; WITH RMVL OF INTRAGASTRIC BARIATRIC BALLON(S)	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
43644	LAPS GSTR RSTCV PX W BYP ROUX-EN-Y LIMB UNDER 150 CM	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
43645	LAPS GSTR RSTCV PX W BYP AND SM INT RCNSTN	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
43647	LAPS IMPLTN/PLCMT GASTRIC NEUROSTIMLTR ELCTRDS ANTRUM	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
43648	LAPS REVISION/RMVL GASTRIC NEUSTIMLTR ELCTRDS ANTRUM	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
43770	LAPS GASTRIC RESTRICTIVE PROCEDURE PLACE DEVICE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
43771	LAPS GASTRIC RESTRICTIVE PX RVSN DEVICE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
43772	LAPS GASTRIC RESTRICTIVE PX REMOVE DEVICE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
43773	LAPS GASTRIC RESTRICTIVE PX REMOVE AND RPLCMT DEVICE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
43774	LAPS GASTRIC RESTRICTIVE PX REMOVE DVCE AND PORT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
43775	LAPS GSTRC RSTRCTIV PX LONGITUDINAL GASTRECTOMY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
43842	GASTRIC RSTCV W O BYP VERTICAL-BANDED GASTROPLY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
43843	GSTR RSTCV W O BYP OTH THN VER-BANDED GSTP	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
43845	GASTRIC RSTCV W PRTL GASTRECTOMY 50-100 CM	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
43846	GASTRIC RSTCV W BYP W SHORT LIMB 150 CM OR LESS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
43847	GASTRIC RSTCV W BYP W SML INTSTN RCNSTN LMIT ABSRPN	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
43848	REVISION OPEN GASTRIC RESTRICTIVE PX NOT DEVICE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
43881	IMPLTN/RPLCMT GASTRIC NRSTIMLTR ELCTRDS ANTRUM OPEN	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
43882	RVSN/RMVL GASTRIC NRSTIMLTR ELCTRDS ANTRUM OPEN	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
43886	GSTR RSTCV PX OPN REVJ SUBQ PORT COMPONENT ONLY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
43887	GSTR RSTCV PX OPN RMVL SUBQ PORT COMPONENT ONLY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
43888	GSTR RSTCV OPN RMVL AND RPLCMT SUBQ PORT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
47610	CHOLECYSTECTOMY W EXPLORATION COMMON DUCT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
47612	CHOLECYSTECTOMY EXPL DUCT CHOLEDOCHOENTEROSTOMY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
49904	OMENTAL FLAP EXTRA-ABDOMINAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
49906	FREE OMENTAL FLAP W MICROVASCULAR ANAST	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
50590	LITHOTRIPSY XTRCORP SHOCK WAVE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
52441	CYSTO INSERTION TRANSPROSTATIC IMPLANT SINGLE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
52649	LASER ENUCLEATION PROSTATE W MORCELLATION	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
53410	URETHROPLASTY 1 STG RECNST MALE ANTERIOR URETHRA	OP Hosp/Amb Surgery Center (ASC) Procedures	Y		No prior auth required for service when associated with a cancer diagnosis.		
53420	URTP 2-STG RCNSTJ/RPR PROSTAT/URETHRA 1ST STAGE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y		No prior auth required for service when associated with a cancer diagnosis.		
53425	URTP 2-STG RCNSTJ/RPR PROSTAT/URETHRA 2ND STAGE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y		No prior auth required for service when associated with a cancer diagnosis.		
53430	URETHROPLASTY RCNSTN FEMALE URETHRA	OP Hosp/Amb Surgery Center (ASC) Procedures	Y		No prior auth required for service when associated with a cancer diagnosis.		
53451	PERIURETHRAL TPRNL ADJTBL BALO CNTNC DEV BI INSJ	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
53452	PERIURETHRAL TPRNL ADJTBL BALO CNTNC DEV UNI INSJ	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
53453	PERIURETHRAL TPRNL ADJTBL BALO CNTNC DEV RMVL EA	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
53454	PERIURETHRAL TPRNL ADJTBL BALO CNTNC DEV ADJMT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
53850	TRURL DSTRJ PRSTATE TISS MICROWAVE THERMOTH	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
53852	TRURL DSTRJ PRSTATE TISS RF THERMOTH	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
53854	TRURL DSTRJ PROSTATE TISS RF WV THERMOTHERAPY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
53865	CYSTOURETHROSCOPY INS TEMP PROS IMPL/STENT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
54125	AMPUTATION PENIS COMPLETE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y		No prior auth required for service when associated with a cancer diagnosis.		
54401	INSRTN PENILE PROSTHESIS INFLATABLE SELF-CONTAINED	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
54405	INSRTN MULTI-COMPONENT INFLATABLE PENILE PROSTHSS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
54410	RMVL AND RPLCMT INFLATABLE PENILE PROSTH SAME SESSN	OP Hosp/Amb Surgery Center (ASC) Procedures	Y		No prior auth required for service when associated with a cancer diagnosis.		
54411	RMVL AND RPLCMT ALL CMPNNTS INFLTBL PENILE PROSTH INFECTED FIELD	OP Hosp/Amb Surgery Center (ASC) Procedures	Y		No prior auth required for service when associated with a cancer diagnosis.		
54416	RMVL & RPLCMT NON-INFLTBL NFLTBL PENILE PROSTHESIS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y		No prior auth required for service when associated with a cancer diagnosis.		
54417	RMVL AND RPLCMT PENILE PROSTHESIS INFECTED FIELD	OP Hosp/Amb Surgery Center (ASC) Procedures	Y		No prior auth required for service when associated with a cancer diagnosis.		
54520	ORCHIECTOMY SIMPLE SCROTAL/INGUINAL APPROACH	OP Hosp/Amb Surgery Center (ASC) Procedures	Y		No prior auth required for service when associated with a cancer diagnosis.		
54690	LAPAROSCOPY SURGICAL ORCHIECTOMY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y		No prior auth required for service when associated with a cancer diagnosis.		
55175	SCROTOPLASTY SIMPLE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y		No prior auth required for service when associated with a cancer diagnosis.		
55180	SCROTOPLASTY COMPLICATED	OP Hosp/Amb Surgery Center (ASC) Procedures	Y		No prior auth required for service when associated with a cancer diagnosis.		
55866	LAPS PROSTECT RETROPUBIC RAD W/NRV SPARING ROBOT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y		No prior auth required for service when associated with a cancer diagnosis.		
55867	LPRSCOPY, SMPL PRSTTECTOMY, SMPLE SUBTOTL (NCLDNG CTRL OF PSTOPRTVE BLEEDING, VSCTOMY, MEATOTMY, URTHRL CALBRTN AND/OR DLTION, AND NTERNL URTHROTOMY), NCLUDS RBTC ASSTNCE, WHN PRFRMD	OP Hosp/Amb Surgery Center (ASC) Procedures	Y		No prior auth required for service when associated with a cancer diagnosis.		
55874	TRANSPERINEAL PLCMNT BIODEGRADABLE MATRL 1 MLT NJX	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
55880	TRANSRECTAL ABLTN MAL PRSTATE TISSUE HIFU W/US	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
55970	INTERSEX SURG MALE FEMALE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y		No prior auth required for service when associated with a cancer diagnosis.		
55980	INTERSEX SURG FEMALE MALE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y		No prior auth required for service when associated with a cancer diagnosis.		
56625	VULVECTOMY SIMPLE COMPLETE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y		No prior auth required for service when associated with a cancer diagnosis.		
56800	PLASTIC REPAIR INTROITUS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y		No prior auth required for service when associated with a cancer diagnosis.		
56805	CLITOROPLASTY INTERSEX STATE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y		No prior auth required for service when associated with a cancer diagnosis.		
57106	VAGINECTOMY PARTIAL REMOVAL VAGINAL WALL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y		No prior auth required for service when associated with a cancer diagnosis.		
57110	VAGINECTOMY COMPLETE REMOVAL VAGINAL WALL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y		No prior auth required for service when associated with a cancer diagnosis.		
57288	SLING OPERATION STRESS INCONTINENCE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
57289	PEREYRA PX W ANTERIOR COLPORRHAPHY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
57291	CONSTRUCTION ARTIFICIAL VAGINA W/O GRAFT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y		No prior auth required for service when associated with a cancer diagnosis.		
57292	CONSTRUCTION ARTIFICIAL VAGINA W/GRAFT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y		No prior auth required for service when associated with a cancer diagnosis.		
57296	REVN W RMVL PROSTHETIC VAGINAL GRAFT OPEN ABDML APPRCH	OP Hosp/Amb Surgery Center (ASC) Procedures	Y		No prior auth required for service when associated with a cancer diagnosis.		
57335	VAGINOPLASTY INTERSEX STATE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y		No prior auth required for service when associated with a cancer diagnosis.		
57426	REVISION PROSTHETIC VAGINAL GRAFT LAPAROSCOPIC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y		No prior auth required for service when associated with a cancer diagnosis.		
58150	TOTAL ABDOMINAL HYSTERECT W WO RMVL TUBE OVARY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58152	TOT ABD HYST W WO RMVL TUBE OVARY W COLPOURETHRXY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58180	SUPRACERVICAL ABDL HYSTER W WO RMVL TUBE OVARY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58200	TOT ABD HYST W PARAORTIC AND PELVIC LYMPH NODE SAM	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58210	RAD ABDL HYSTERECTOMY W BI PELVIC LMPHADENECTOMY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58240	PEL EXNTJ GYNECOLOGIC MAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58260	VAGINAL HYSTERECTOMY UTERUS 250 GM OR LESS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58262	VAG HYST 250 GM OR LESS W RMVL TUBE AND OVARY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58263	VAG HYST 250 GM OR LESS W RMVL TUBE OVARY W RPR NTRCL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58267	VAG HYST 250 GM OR LESS W COLPO-URTCSTOPEXY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58270	VAGINAL HYSTERECTOMY 250 GM OR LESS W RPR ENTEROCELE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58285	VAGINAL HYSTERECTOMY RADICAL SCHAUTA OPERATION	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58290	VAGINAL HYSTERECTOMY UTERUS OVER 250 GM	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58291	VAG HYST OVER 250 GM RMVL TUBE AND OVARY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58292	VAG HYST OVER 250 GM RMVL TUBE AND OVARY W RPR ENTRCLE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58294	VAGINAL HYSTERECTOMY OVER 250 GM RPR ENTEROCELE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58321	ARTIFICIAL INSEMINATION INTRA-CERVICAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58322	ARTIFICIAL INSEMINATION INTRA-UTERINE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58323	SPERM WASHING ARTIFICIAL INSEMINATION	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58345	TRANSCERV FALLOPIAN TUBE CATH W WO HYSTOSALPING	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58350	CHROMOTUBATION OVIDUCT W MATERIALS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				

58356	ENDOMETRIAL CRYOABLATION W US AND ENDOMETRIAL CR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58540	HYSTEROPLASTY RPR UTERINE ANOMALY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58541	LAPAROSCOPY SUPRACERVICAL HYSTERECTOMY 250 GM OR LESS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58542	LAPS SUPRACRV HYSTERECT 250 GM OR LESS RMVL TUBE OVAR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58543	LAPS SUPRACERVICAL HYSTERECTOMY OVER 250	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58544	LAPS SUPRACRV HYSTEREC OVER 250 G RMVL TUBE OVARY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58545	LAPS MYOMECTOMY EXC 1-4 MYOMAS 250 GM OR LESS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58546	LAPS MYOMECTOMY EXC 5 OR GRT MYOMAS OVER 250 GRAMS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58550	LAPS VAGINAL HYSTERECTOMY UTERUS 250 GM OR LESS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58552	LAPS W VAG HYSTERECT 250 GM AND RMVL TUBE AND OVARIES	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58553	LAPS W VAGINAL HYSTERECTOMY OVER 250 GRAMS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58554	LAPS VAGINAL HYSTERECT OVER 250 GM RMVL TUBE AND OVAR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58570	LAPAROSCOPY W TOTAL HYSTERECTOMY UTERUS 250 GM OR LESS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58571	LAPS TOTAL HYSTERECT 250 GM OR LESS W RMVL TUBE OVARY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58572	LAPAROSCOPY TOTAL HYSTERECTOMY UTERUS OVER 250 GM	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58573	LAPAROSCOPY TOT HYSTERECTOMY OVER 250 G W TUBE OVAR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58660	LAPAROSCOPY W LYSIS OF ADHESIONS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58661	LAPAROSCOPY W RMVL ADNEXAL STRUCTURES	OP Hosp/Amb Surgery Center (ASC) Procedures	Y		No PA Required with encounter for sterilization done as outpatient. Still requires PA in other settings.		
58662	LAPS FULG EXC OVARY VISCERA PERITONEAL SURFACE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58672	LAPAROSCOPY FIMBRIOPLASTY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58673	LAPAROSCOPY SALPINGOSTOMY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58720	SALPINGO-OOPHORECTOMY COMPL PRTL UNI BI SPX	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58740	LYSIS OF ADHESIONS SALPINX OVARY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58750	TUBOTUBAL ANASTATOMOSIS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58752	TUBOUTERINE IMPLANTATION	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58760	FIMBRIOPLASTY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58770	SALPINGOSTOMY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58940	OOPHORECTOMY PARTIAL TOTAL UNI BI	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58970	FOLLICLE PUNCTURE OOCYTE RETRIEVAL ANY METHOD	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58974	EMBRYO TRANSFER INTRAUTERINE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
58976	GAMETE ZYGOTE EMBRYO FALLOPIAN TRANSFER ANY METHOD	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
61863	STRTCTC IMPLTJ NSTIM ELTRD W O RECORD 1ST ARRAY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
61867	STRTCTC IMPLTJ NSTIM ELTRD W RECORD 1ST ARRAY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
61885	INSJ RPLCMT CRANIAL NEUROSTIM PULSE GENERATOR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
61886	INSJ RPLCMT CRANIAL NEUROSTIM GENER 2 OR GRT ELTRDS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
62324	NJX CONTINUOUS INFUSION OR INTERMITTENT BOLUS PLACEMENT DX/THER SBST	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
62325	NJX CONTINUOUS INFUSION OR INTERMITTENT BOLUS DX/THER SBST INTRLMNR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
62326	NJX CONTINUOUS INFUSION OR INTERMITTENT BOLUS DX/THER SBST INTRLMNR LMBR/SAC W/O IMG GDN	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
62327	NJX CONTINUOUS INFUSION OR INTERMITTENT BOLUS DX THER SBST INTRLMNR LMBR SAC W IMG GDN	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
62380	NDSC DCMPRN SPINAL CORD 1 W LAMOT NTRSPC LUMBAR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
63001	LAM W O FACETEC FORAMOT DSKC 1 2 VRT SEG CRV	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
63003	LAMINECTOMY W O FFD 1 2 VERT SEG THORACIC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
63005	LAMINECTOMY W O FFD 1 2 VERT SEG LUMBAR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
63011	LAMINECTOMY W O FFD 1 2 VERT SEG SACRAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
63012	LAMINECTOMY W RMVL ABNORMAL FACETS LUMBAR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
63015	LAMINECTOMY W O FFD OVER 2 VERT SEG CERVICAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
63016	LAMINECTOMY W O FFD OVER 2 VERT SEG THORACIC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
63017	LAMINECTOMY W O FFD OVER 2 VERT SEG LUMBAR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
63020	LAMNOTMY INCL W DCMPRSN NRV ROOT 1 INTRSPC CERVC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
63030	LAMNOTMY INCL W DCMPRSN NRV ROOT 1 INTRSPC LUMBR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
63040	LAMOT PRTL FFD EXC DISC REEXPL 1 NTRSPC CERVICAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
63042	LAMOT PRTL FFD EXC DISC REEXPL 1 NTRSPC LUMBAR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
63045	LAM FACETECTOMY AND FORAMOTOMY 1 SEGMENT CERVICAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
63046	LAM FACETECTOMY AND FORAMOTOMY 1 SEGMENT THORACIC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
63047	LAM FACETECTOMY AND FORAMOTOMY 1 SEGMENT LUMBAR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
63048	LAM FACETECTOMY AND FORAMTOMY 1 SGM EA CRV THRC/LMBR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
63050	LAMOP CERVICAL W DCMPRN SPI CORD 2 OR GRT VERT SEG	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
63051	LAMOPLASTY CERVICAL DCMPRN CORD 2 OR GRT SEG RCNSTJ	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
63052	LAM FACETEC/FORAMOT DRG ARTHRD LUMBAR 1 VRT SGM	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
63053	LAM FACETEC/FORAMOT DRG ARTHRD LMBR EA ADDL SGM	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
63055	TRANSPEDICULAR DCMPRN SPINAL CORD 1 SEG THORACIC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
63056	TRANSPEDICULAR DCMPRN SPINAL CORD 1 SEG LUMBAR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
63057	TRANSPEDICULAR DCMPRN 1 SEG EA THORACIC/LUMBAR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
63064	COSTOVERTEBRAL DCMPRN SPINAL CORD THORACIC 1 SEG	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
63075	DISCECTOMY ANT DCMPRN CORD CERVICAL 1 NTRSPC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
63076	DISCECTOMY ANT DCMPRN CORD CERVICAL EA NTRSPC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
63077	DISCECTOMY ANT DCMPRN CORD THORACIC 1 NTRSPC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
63081	VERTEBRAL CORPECTOMY ANT DCMPRN CERVICAL 1 SEG	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
63087	VCRPEC THORACOLMBR DCMPRN LWR THRC LMBR 1 SEG	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
63090	VCRPEC TRANSPRTL RPR DCMPRN THRC LMBR SAC 1 SEG	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
63300	VCRPEC LES 1 SGM XDRL CERVICAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
63304	VERTEBRAL CORPECTOMY EXC LES 1 SEG IDRL CERVICAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
63308	VERTEBRAL CORPECTOMY EXC INDRL LES EACH SEG	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
64553	PRQ IMPLTJ NEUROSTIMULATOR ELTRD CRANIAL NERVE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
64568	INC IMPLTJ CRNL NRV NSTIM ELTRDS AND PULSE GENER	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
64569	REVISION REPLMT NEUROSTIMLATOR ELTRD CRANIAL NRV	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
64570	REMOVAL CRNL NRV NSTIM ELTRDS AND PULSE GENERATO	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
64582	OPEN IMPLTJ HPGLSL NRV NSTIM RA PG AND RESPIR SENSOR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
64584	REMOVAL HYPOGLOSSAL NERVE NSTIM RA PG AND RESPIR SNR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
64590	INSERTION RPLCMT PERIPHERAL GASTRIC NPGR	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
64912	NERVE REPAIR W NERVE ALLOGRAFT FIRST STRAND	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
65771	RADIAL KERATOTOMY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
65775	CRNL WEDGE RESCJ CORRJ INDUCED ASTIGMATISM	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
69714	IMPLTJ OSSEOINTEGRATED TEMPORAL BONE W MASTOID	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
69716	IMPLTJ OI IMPLT SKULL MAG TC ATTACHMENT ESP	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
69729	IMPL OI IMPLT SKULL MAG TC ATTACHMENT ESP GT or equal to 1	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
69730	RPLCMT OI IMPLT SKULL MAG TC ATTACHMENT ESP GT or equal to	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
69930	COCHLEAR DEVICE IMPLANTATION W WO MASTOIDECTOMY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
76932	US ENDOMYOCARDIAL BIOPSY RS AND I	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
76984	DX INTRAOP THORACIC AORTA US	OP Hosp/Amb Surgery Center (ASC) procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	NC	
76987	DX INTRAOP EPICAR CAR US CHD	OP Hosp/Amb Surgery Center (ASC) procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	NC	
76988	DX NTROP EPCR US CHD IMG ACQ	OP Hosp/Amb Surgery Center (ASC) procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	NC	
76989	DX INTRAOP EPCAR US CHD I&R	OP Hosp/Amb Surgery Center (ASC) procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	NC	
92920	PRQ TRLUML CORONARY ANGIOPLASTY ONE ART/BRANCH	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
92924	PRQ TRLUML CORONARY ANGIO/ATHERECT ONE ART/BRNCH	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
92928	PRQ TRLUML CORONARY STENT W/ANGIO ONE ART/BRNCH	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
92933	PRQ TRLUML CORONRY STENT/ATH/ANGIO ONE ART/BRNCH	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
92937	PRQ TRLUML CORONARY BYP GRFT REVASC ONE VESSEL	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
92941	PRQ TRLUML CORONRY TOT OCCLUS REVASC MI ONE VSL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
92943	PRQ TRLUML CORONRY CHRONIC OCCLUS REVASC ONE VSL	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
92960	CARDIOVERSION ELECTIVE ARRHYTHMIA EXTERNAL	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
92961	CARDIOVERSION ELECTIVE ARRHYTHMIA INTERNAL SPX	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
92970	CARDIOASSIST-METH CIRCULATORY ASSIST INTERNAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
92971	CARDIOASSIST-METH CIRCULATORY ASSIST EXTERNAL	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
92972	PERQ TRLUML CORONRY LITHOTRP	OP Hosp/Amb Surgery Center (ASC) procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	NC	
92973	PRQ TRANSLUMINAL CORONARY MECHANICL THROMBECTOMY	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
92974	TCAT PLACEMENT RADJ DLVR DEV SBSQ C IV BRACHYTX	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
92975	THROMBOLYSIS INTRACORONARY NFS SLCTV ANGRPH	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
92977	THROMBOLYSIS CORONARY INTRAVENOUS INFUSION	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
92986	PRQ BALLOON VALVULOPLASTY AORTIC VALVE	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
92987	PRQ BALLOON VALVULOPLASTY MITRAL VALVE	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
92990	PRQ BALLOON VALVULOPLASTY PULMONARY VALVE	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
92997	PRQ TRLUML PULMONARY ART BALLOON ANGIOP 1 VSL	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93015	CV STRS TST XERS&/OR RX CONT ECG W/SI&R	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93016	CV STRS TST XERS&/OR RX CONT ECG W/O I&R	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93017	CV STRS TST XERS&/OR RX CONT ECG TRCG ONLY	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93018	CV STRS TST XERS&/OR RX CONT ECG I&R ONLY	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93025	MICROVOLT T-WAVE ASSESS VENTRICULAR ARRHYTHMIAS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
93227	XTRNL ECG CONTINUOUS RHYTHM W/I&R UP TO 48 HRS	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93228	XTRNL MOBILE CV TELEMETRY W/I&REPORT 30 DAYS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
93229	XTRNL MOBILE CV TELEMETRY W/TECHNICAL SUPPORT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
93260	PRGRMG DEV EVAL IMPLANTABLE SUBQ LEAD DFB SYSTEM	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93261	INTERROGATION EVAL F2F IMPLANT SUBQ LEAD DEFIB	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93264	REMOTE MNTR WIRELESS P-ART PRS SNR UP TO 30 D	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93268	XTRNL PT ACTIV ECG TRANSMIS W/R&I </30 DAYS	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93270	XTRNL PT ACTIVATED ECG RECORD MONITOR 30 DAYS	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93271	XTRNL PT ACTIVATED ECG REC DWNLD 30 DAYS	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93272	XTRNL PT ACTVTD ECG DWNLD W/R&I </30 DAYS	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93279	PROGRAM EVAL IMPLANTABLE IN PRSN 1 LD PACEMAKER	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93280	PROGRAM EVAL IMPLANTABLE IN PERSN DUAL LD PACER	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93281	PROGRAM EVAL IMPLANTABLE IN PRSN MULTI LD PACER	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93282	PRGRMG DEV EVAL IMPLANTABLE IN PERSN 1 LD DFB	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93283	PRGRMG EVAL IMPLANTABLE IN PRSN DUAL LEAD DFB	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93284	PRGRMG EVAL IMPLANTABLE IN PERSON MULTI LEAD DFB	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93285	PROGRAM EVAL IMPLANTABLE DEV IN PRSN ILR SYSTEM	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93286	PERI-PX EVAL&PROGRAM IN PRSN PACEMAKER SYSTEM	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93287	PERI-PX DEV EVAL & PROG SING/DUAL/MULTI LEAD DFB	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93288	INTERROGATION EVAL IN PERSON 1/DUAL/MLT LEAD PM	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93289	INTERROG EVAL F2F 1/DUAL/MLT LEADS IMPLTBL DFB	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93290	INTERROGATION EVAL F2F IMPLANTABLE CV MNTR SYS	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93291	INTERROGATION EVALUATION IN PERSON ILR SYSTEM	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93292	INTERROGATION EVAL IN PERSON WR DEFIBRILLATOR	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93293	TRANSTELEPHONIC RHYTHM STRIP PACEMAKER EVAL	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93319	3D ECHO IMG & PST-PXESSING TEE/TTE CGEN CAR ANOMAL	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93462	LEFT HEART CATH BY TRANSEPTAL PUNCTURE	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93503	INSERTION FLOW DIRECTED CATHETER FOR MONITORING	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93505	ENDOMYOCARDIAL BIOPSY	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93567	NJX SUPRAVALV AORTOG HRT CATH W/S&I	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93568	NJX PULMONARY ANGIO HRT CATH W/S&I	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93580	PRQ TCAT CLSR CGEN INTRATRL COMUNICAJ W/IMPLT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
93581	PRQ TCAT CLSR CGEN VENTR SEPTAL DFCT W/IMPLT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
93582	PERCUTAN TRANSCATH CLOSURE PAT DUCT ARTERIOSUS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
93583	PERCUTANEOUS TRANSCATHETER SEPTAL REDUCTION THER	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
93584	VNGRPH CHD ANOM/PERSIST SVC	OP Hosp/Amb Surgery Center (ASC) procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	NC	
93585	VNGRPH CHD AZYGS/HEMIAZYGS	OP Hosp/Amb Surgery Center (ASC) procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	NC	
93586	VNGRPH CHD CORONARY SINUS	OP Hosp/Amb Surgery Center (ASC) procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	NC	
93587	VNGRPH CHD VNVN CLTRL AT/ABV	OP Hosp/Amb Surgery Center (ASC) procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	NC	
93588	VNGRPH CHD VNVN CLTRL BELOW	OP Hosp/Amb Surgery Center (ASC) procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	NC	
93590	PERQ TRANSCATH CLS PARAVALVR LEAK 1 MITRAL VALVE	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93591	PERQ TRANSCATH CLS PARAVALVR LEAK 1 AORTIC VALVE	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93593	R HRT CATH CHD W/IMG CATH TRGT ZONE NML NTV CONNCTNS	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93594	R HRT CATH CHD W/IMG CATH TRGT ZON ABNL NTVE CONNCTNS	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93595	L HRT CATH CHD IMG CATH TRGT ZON NML/ABNL NTV CNCTNS	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93596	R & L HRT CATH CHD IMG CATH TRGT ZONE NML NTV CONNCTNS	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93597	R & L HRT CATH CHD IMG CATH TRGT ZON ABNL NTV CONNCTNS	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93598	CAR OUTP MEAS DRG CAR CATH EVAL CGEN HRT DEFECT	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93600	BUNDLE OF HIS RECORDING	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93602	INTRA-ATRIAL RECORDING	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93603	RIGHT VENTRICULAR RECORDING	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93610	INTRA-ATRIAL PACING	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93612	INTRAVENTRICULAR PACING	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93613	INTRACARDIAC ELECTROPHYSIOLOGIC 3D MAPPING	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93615	ESOPHGL REC ATRIAL W/WO VENTRICULAR ELECTROGRAMS	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93616	ESOPHGL REC ATRIAL W/WO VENTR ELECTRGRAMS W/PACG	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93618	INDUCTION ARRHYTHMIA ELECTRICAL PACING	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93619	COMPRE ELECTROPHYSIOLOGIC W/O ARRHYT INDUCTION	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93620	COMPRE ELECTROPHYSIOLOGIC ARRHYTHMIA INDUCTION	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93623	PROGRAMMED STIMJ & PACG AFTER IV DRUG NFS	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93624	ELECTROPHYSIOLOGIC FOLLOW-UP W/PAC/REC W/ARRHYT	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93631	INTRAOP EPICAR AND ENDOCAR PACG AND MAPG	OP Hosp/Amb Surgery Center (ASC) Procedures	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
93640	EPHYS EVAL PACG CVDFB LDS INITIAL IMPLAN/REPLACE	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93641	EPHYS EVAL PACG CVDFB LDS W/TSTG OF PULSE GEN	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93642	EPHYS EVAL PACG CVDFB PRGRMG/REPRGRMG PARAMETERS	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93644	EPHYS EVAL SUBQ IMPLANTABLE DEFIBRILLATOR	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93650	ICAR CATHETER ABLATION ATRIOVENTR NODE FUNCTION	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93653	EPHYS EVAL W/ABLATION SUPRAVENT ARRHYTHMIA	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93654	EPHYS EVAL W/ABLATION VENTRICULAR TACHYCARDIA	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93656	EPHYS EVL TRNSPTL TX ATRIAL FIB ISOLAT PULM VEIN	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93660	CARDIOVASCULAR FUNCTION EVAL W/TILT TABLE W/MNTR	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93662	INTRACARD ECHOCARD W/THER/DX IVNTJ INCL IMG S & I	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93724	ELECTRONIC ANALYSIS ANTITACHY PACEMAKER SYSTEM	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93784	AMBL BLD PRESS W/TAPE&/DISK 24/> HR ALYS I&R	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93786	BL BLD PRESS W/TAPE&/DISK 24/> HR REC ONL	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93788	AMBL BLD PRESS W/TAPE/DISK 24/>HR ALYS W/REPRT	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
93790	AMBL BLD PRESS TAPE&/DISK 24/> HR REVIEW	OP Hosp/Amb Surgery Center (ASC) Procedures	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, no PA required for Outpatient.	Y	
96567	PDT DSTR PRMLG LES SKN ILLUM ACTIVJ PER DAY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
96570	PDT NDSC ABL ABNOR TISS VIA ACTIVJ RX 30 MIN	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
96571	PDT NDSC ABL ABNOR TISS VIA ACTIVJ RX A 15 MIN	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
96573	PDT DSTR PRMLG LES SKN ILLUM ACTIVJ BY PHYS QHP	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
96574	DEBRIDEMENT PRMLG HYPERKERATOTIC LES W PDT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
96900	ACTINOTHERAPY ULTRAVIOLET LIGHT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
96902	MCRSCP XM HAIR PLUCK CLIP FOR CNTS STRUCT ABNORM	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
96910	PHOTOCHEMOTX TAR AND UVB PETROLATUM UVB	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
96912	PHOTOCHEMOTX PSORALENS AND ULTRAVIOLET PUVA	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
96913	PHOTOCHEMOTHERAPY DERMATOSES 4-8 HRS SUPERVISION	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
96920	LASER SKIN DISEASE PSORIASIS TOT AREA UNDER 250 SQ CM	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
96921	LASER SKIN DISEASE PSORIASIS 250-500 SQ CM	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
96922	LASER SKIN DISEASE PSORIASIS OVER 500 SQ CM	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
96932	RCM CELULR AND SUBCELULR SKN IMGNG IMG ACQUISITION	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
96933	RCM CELULR AND SUBCELULR SKN IMGNG I AND R 1ST LES	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
0402T	COLLAGEN CROSS-LINKING OF CORNEA MED SEPARATE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
0480T	FRACTIONAL ABL LSR FENESTRATION EA ADDL 100 SQCM	OP Hosp/Amb Surgery Center (ASC) procedures	Y				
0674T	LAPS INSJ NEW/RPLCMT PERM ISDSS AGMNTJ CAR FUNCJ	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
0675T	LAPS INSJ NEW/RPLCMT LEAD PERM ISDSS 1ST LEAD	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
0676T	LAPS INSJ NEW/RPLCMT LEAD PERM ISDSS EA ADL LEAD	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
0677T	LAPS REPOS LEAD PERM ISDSS 1ST REPOSITIONED LEAD	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
0678T	LAPS REPOS LEAD PERM ISDSS EA ADDL REPOS LEAD	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
0679T	LAPAROSCOPIC REMOVAL LEAD PERM ISDSS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
0680T	INSJ/RPLCMT PULSE GENERATOR ONLY ISDSS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
0681T	RELOCATION PULSE GENERATOR ONLY ISDSS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
0682T	REMOVAL PULSE GENERATOR ONLY ISDSS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
0683T	PROGRAMMING DEVICE EVALUATION IN PERSON ISDSS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
0684T	PERIPROCEDURAL DEVICE EVALUATION IN PERSON ISDSS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
0685T	INTERROGATION DEVICE EVALUATION IN PERSON ISDSS	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
0707T	NJX BONE SUB MATRL INTO SUBCHONDRAL BONE DEFECT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
C2616	BRACHYTHERAPY NONSTRANDED YTTRIUM-90 PER SOURCE	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
C9757	LAMINOTOMY DECOMP NERVE ROOT; 1 INTERSPACE LUMB	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
C9761	CYSTO URS &/PYELOSCPY LITH & VAC ASPIR KDNY COLLCTN SYSTM	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
C9765	REV EVAR ANY VES;IV LITHOTRIPSY AND TL STENT PLCMT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
C9766	REV EVAR ANY VES);IV LITHOTRIPSY AND ATHERECTOMY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
C9767	REV EVAR ANY VES;IV LITHO AND TL STNT PLCMT AND ATHERECT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
C9772	RVSC EVAR OPN/PERC TIB/PER ART IVASC LITHOTRIPSY	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
C9773	RVSC EVAR OPEN/PC TIBIAL/PA;IVASC LITH AND TL SP	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
C9774	RVSC EVAR OPN/PERQ TIB/PER ART;IVASC LITH AND ATHREC	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
C9775	RVSC EVAR OPN/P TIB/PA;IVASC LITH AND TL STNT PL AND ATH	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
J7330	AUTOLOGOUS CULTURED CHONDROCYTES IMPLANT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
S2095	TRNSCATH OCCL EMBOLIZ TUMR DESTRUC PERQ METH USI	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
S2118	METL-ON-METL TOT HIP RESRFC ACETAB AND FEM CMPNT	OP Hosp/Amb Surgery Center (ASC) Procedures	Y				
27278	ARTHRD SI JT PERQ IMG GDN INCL PLMT IARTIC IMPLT W/O PLCMNT OF TRNFXTN DVCE	Pain Management Procedures	Y				
27279	ARTHRODESIS SACROILIAC JOINT PERCUTANEOUS	Pain Management Procedures	Y				
62263	PRQ LYSIS EPIDURAL ADHESIONS MULT SESS 2 OR GRT DAYS	Pain Management Procedures	Y				
62264	PRQ LYSIS EPIDURAL ADHESIONS MULT SESSIONS 1 DAY	Pain Management Procedures	Y				
62320	NJX DX/THER SBST INTRLMNR CRV/THRC W/O IMG GDN	Pain Management Procedures	Y				
62321	NJX DX/THER SBST INTRLMNR CRV/THRC W/IMG GDN	Pain Management Procedures	Y				
62322	NJX DX THER SBST INTRLMNR LMBR SAC W O IMG GDN	Pain Management Procedures	Y				
62323	NJX DX THER SBST INTRLMNR LMBR SAC W IMG GDN	Pain Management Procedures	Y				
62351	IMPLTJ REVJ RPSG ITHCL EDRL CATH W LAM	Pain Management Procedures	Y				
62360	IMPLTJ RPLCMT ITHCL EDRL DRUG NFS SUBQ RSVR	Pain Management Procedures	Y				

62361	IMPLTJ RPLCMT FS NON-PRGRBL PUMP	Pain Management Procedures	Y				
62362	IMPLTJ RPLCMT ITHCL EDRL DRUG NFS PRGRBL PUMP	Pain Management Procedures	Y				
63650	PRQ IMPLTJ NSTIM ELECTRODE ARRAY EPIDURAL	Pain Management Procedures	Y				
63655	LAM IMPLTJ NSTIM ELTRDS PLATE PADDLE EDRL	Pain Management Procedures	Y				
63663	REVJ INCL RPLCMT NSTIM ELTRD PRQ RA INCL FLUOR	Pain Management Procedures	Y				
63664	REVJ INCL RPLCMT NSTIM ELTRD PLT PDLE INCL FLUOR	Pain Management Procedures	Y				
63685	INSJ RPLCMT SPI NPGR DIR INDUXIVE COUPLING	Pain Management Procedures	Y				
63688	REVJ RMVL IMPLANTED SPINAL NEUROSTIM GENERATOR	Pain Management Procedures	Y				
64450	INJECTION ANES OTHER PERIPHERAL NERVE BRANCH	Pain Management Procedures	Y		No PA required in office or ASC setting. PA required if done in hospital setting outside of another procedure. No PA required if combined with another surgical procedure.		
64451	INJECTION AA AND STRD NERVES NRVTG SI JOINT W IMG	Pain Management Procedures	Y				
64454	INJECTION AA AND STRD GENICULAR NRV BRANCHES W IMG	Pain Management Procedures	Y				
64479	NJX ANES AND STRD W IMG TFRML EDRL CRV THRC 1 LVL	Pain Management Procedures	Y				
64480	NJX ANES AND STRD W IMG TFRML EDRL CRV THRC EA LV	Pain Management Procedures	Y				
64483	NJX ANES AND STRD W IMG TFRML EDRL LMBR SAC 1 LVL	Pain Management Procedures	Y				
64484	NJX ANES AND STRD W IMG TFRML EDRL LMBR SAC EA LV	Pain Management Procedures	Y				
64490	NJX DX THER AGT PVRT FACET JT CRV THRC 1 LEVEL	Pain Management Procedures	Y				
64491	NJX DX THER AGT PVRT FACET JT CRV THRC 2ND LEVEL	Pain Management Procedures	Y				
64492	NJX DX THER AGT PVRT FACET JT CRV THRC 3 PLUS LEVEL	Pain Management Procedures	Y				
64493	NJX DX THER AGT PVRT FACET JT LMBR SAC 1 LEVEL	Pain Management Procedures	Y				
64494	NJX DX THER AGT PVRT FACET JT LMBR SAC 2ND LEVEL	Pain Management Procedures	Y				
64495	NJX DX THER AGT PVRT FACET JT LMBR SAC 3 PLUS LEVEL	Pain Management Procedures	Y				
64624	DESTRUCTION NEUROLYTIC AGT GENICULAR NERVE W IMG	Pain Management Procedures	Y				
64625	RADIOFREQUENCY ABLTJ NRV NRVTG SI JT W IMG GDN	Pain Management Procedures	Y				
64628	THERMAL DSTRJ INTRAOSSEOUS BVN 1ST 2 LMBR/SAC	Pain Management Procedures	Y				
64633	DSTR NROLYTC AGNT PARVERTEB FCT SNGL CRVCL THORA	Pain Management Procedures	Y				
64634	DSTR NROLYTC AGNT PARVERTEB FCT ADDL CRVCL THORA	Pain Management Procedures	Y				
64635	DSTR NROLYTC AGNT PARVERTEB FCT SNGL LMBR SACRAL	Pain Management Procedures	Y				
64636	DSTR NROLYTC AGNT PARVERTEB FCT ADDL LMBR SACRAL	Pain Management Procedures	Y				
64640	DSTRJ NEUROLYTIC AGENT OTHER PERIPHERAL NERVE	Pain Management Procedures	Y				
92507	TX SPEECH LANG VOICE COMMN AND AUDITORY PROC IND	Physical, Occupational, and Speech Therapy	Y		PA Required after 12 visits per calendar year for PT/OT/ST.		
92508	TX SPEECH LANGUAGE VOICE COMMN AUDITRY 2 OR MORE INDVL	Physical, Occupational, and Speech Therapy	Y		PA Required after 12 visits per calendar year for PT/OT/ST.		
92630	AUDITORY REHABILITATION PRELINGUAL HEARING LOSS	Physical, Occupational, and Speech Therapy	Y		PA Required after 12 visits per calendar year for PT/OT/ST.		
92633	AUDITORY REHABILITATION POSTLINGUAL HEARING LOSS	Physical, Occupational, and Speech Therapy	Y		PA Required after 12 visits per calendar year for PT/OT/ST.		
97110	THERAPEUTIC PX 1/> AREAS EACH 15 MIN EXERCISES	Physical, Occupational, and Speech Therapy	Y		PA Required after 12 visits per calendar year for PT/OT/ST.		
97112	THER PX 1/> AREAS EACH 15 MIN NEUROMUSC REEDUCAN	Physical, Occupational, and Speech Therapy	Y		PA Required after 12 visits per calendar year for PT/OT/ST.		
97113	THER PX 1 OR MORE AREAS EACH 15 MIN AQUA THRPY W/EXERCSS	Physical, Occupational, and Speech Therapy	Y		PA Required after 12 visits per calendar year for PT/OT/ST.		
97116	THER PX 1 OR MORE AREAS EA 15 MIN GAIT TRAING W/STAIR	Physical, Occupational, and Speech Therapy	Y		PA Required after 12 visits per calendar year for PT/OT/ST.		
97124	THER PX 1 OR GT AREAS EACH 15 MINUTES MASSAGE	Physical, Occupational, and Speech Therapy	Y		PA Required after 12 visits per calendar year for PT/OT/ST.		
97129	THER INTVJ COG FUNCJ CNTCT 1ST 15 MINUTES	Physical, Occupational, and Speech Therapy	Y		PA Required after 12 visits per calendar year for PT/OT/ST.		
97130	THER INTVN COG FUNCJ CNTCT EA ADDL 15 MINUTES	Physical, Occupational, and Speech Therapy	Y		PA Required after 12 visits per calendar year for PT/OT/ST.		
97140	MANUAL THERAPY TQS 1/> REGIONS EACH 15 MINUTES	Physical, Occupational, and Speech Therapy	Y		PA Required after 12 visits per calendar year for PT/OT/ST.		
97150	THERAPEUTIC PROCEDURES GROUP 2 OR MORE INDVDUALS	Physical, Occupational, and Speech Therapy	Y		PA Required after 12 visits per calendar year for PT/OT/ST.		
97530	THERAPEUT ACTIVITY DIRECT PT CONTACT EACH 15 MIN	Physical, Occupational, and Speech Therapy	Y		PA Required after 12 visits per calendar year for PT/OT/ST.		
97533	SENSORY INTEGRATIVE TECHNIQUES EACH 15 MINUTES	Physical, Occupational, and Speech Therapy	Y		PA Required after 12 visits per calendar year for PT/OT/ST.		
97535	SELF-CARE/HOME MGMT TRAINING EACH 15 MINUTES	Physical, Occupational, and Speech Therapy	Y		PA Required after 12 visits per calendar year for PT/OT/ST.		
S8940	EQUESTRIAN/HIPPOTHERAPY PER SESSION	Physical, Occupational, and Speech Therapy	Y				
L0462	TLSO TRIPLANAR 3 SHELL ANT TO STERNL NOTCH PRFAB	Prosthetics & Orthotics	Y				
L0480	TLSO TRIPLANAR 1 PIECE W O INTERFCE LINER CSTM	Prosthetics & Orthotics	Y				
L0482	TLSO TRIPLANAR 1 PIECE W INTERFCE LINER CSTM	Prosthetics & Orthotics	Y				
L0484	TLSO TRIPLANAR 2 PIECE W O INTERFCE LINER CSTM	Prosthetics & Orthotics	Y				
L0486	TLSO TRIPLANAR 2 PIECE W INTERFCE LINER CSTM	Prosthetics & Orthotics	Y				
L0636	LSO SAGITTAL-CORONL CNTRL FLEX RIGID POST CUSTOM	Prosthetics & Orthotics	Y				
L0637	LUMB-SACRAL ORTHOS SAG-COR CNTRL RIGD A AND P PREFAB	Prosthetics & Orthotics	Y				
L0640	LSO SAGITTAL-CORONAL RIGID SHELL PANEL CUSTM FAB	Prosthetics & Orthotics	Y				
L0650	LSO SAGITTAL-CORONAL CONTRL RIGID ANT POST PANELS	Prosthetics & Orthotics	Y				
L0700	CTLSO ANT-POSTERIOR-LAT CONTROL MOLDED PT MODEL	Prosthetics & Orthotics	Y				
L0710	CTLSO ANT-POST-LAT CNTRL MOLD PT-INTRFCE MATL	Prosthetics & Orthotics	Y				
L0720	CTLSO A-P-L CONTROL CUSTOM	Prosthetics & Orthotics	Y				
L0999	ADD TO SPINAL ORTHOTIC NOT OTHERWISE SPECIFIED	Prosthetics & Orthotics	Y				
L1000	CTLSO INCLUSIVE FURNISHING INIT ORTHOS INCL MDL	Prosthetics & Orthotics	Y				
L1005	TENSION BASED SCOLIOSIS ORTHOTIC AND ACCESSORY PADS	Prosthetics & Orthotics	Y				
L1200	TLSO INCLUSIVE FURNISHING INITIAL ORTHOSIS ONLY	Prosthetics & Orthotics	Y				
L1499	SPINAL ORTHOTIC NOT OTHERWISE SPECIFIED	Prosthetics & Orthotics	Y				
L1680	HIP ORTHOT DYN PELV CONTROL THIGH CUFF CSTM FAB	Prosthetics & Orthotics	Y				
L1685	HIP ORTHOS ABDCT CNTRL POSTOP HIP ABDCT CSTM	Prosthetics & Orthotics	Y				
L1730	LEGG PERTHES ORTHOTIC SCOTTISH RITE CUSTOM FAB	Prosthetics & Orthotics	Y				
L1834	KO WITHOUT KNEE JOINT RIGID CUSTOM FABRICATED	Prosthetics & Orthotics	Y				
L1840	KO DEROTATION MEDIAL-LATERAL ACL CUSTOM FAB	Prosthetics & Orthotics	Y				
L1844	KNEE ORTHOSIS SINGLE UPRIGHT THIGH AND CALF CUSTOM	Prosthetics & Orthotics	Y				
L1846	KNEE ORTHOSIS DOUBLE UPRIGHT THIGH AND CALF CUSTOM	Prosthetics & Orthotics	Y				
L1860	KNEE ORTHOS MOD SUPRACONDYLR PROS SOCKT CSTM FAB	Prosthetics & Orthotics	Y				
L1900	AFO SPRING WIRE DORSIFLX ASST CALF BAND CSTM FAB	Prosthetics & Orthotics	Y				
L1945	AFO MOLD PT MDL PLSTC RIGD ANT TIBL SECT CSTM	Prosthetics & Orthotics	Y				
L1950	ANKLE FOOT ORTHOTIC SPIRAL PLASTIC CUSTOM-FAB	Prosthetics & Orthotics	Y				
L1970	AFO PLASTIC WITH ANKLE JOINT CUSTOM FABRICATED	Prosthetics & Orthotics	Y				
L2000	KAFO 1 UPRT FREE KNEE FREE ANK SOLID STIRUP CSTM	Prosthetics & Orthotics	Y				
L2005	KAFO ANY MATL AUTO LOCK AND SWNG RLSE W ANK JNT CSTM	Prosthetics & Orthotics	Y				
L2006	KAF DVC ANY MATERIAL ADJUSTABILITY CUSTOM FAB	Prosthetics & Orthotics	Y				
L2010	KAFO 1 UPRT SOLID STIRUP W O KNEE JNT CSTM FAB	Prosthetics & Orthotics	Y				
L2020	KAFO DBL UPRT SOLID STIRUP THI AND CALF CSTM FAB	Prosthetics & Orthotics	Y				
L2030	KAFO DBL UPRT SOLID STIRUP W O KNEE JNT CSTM	Prosthetics & Orthotics	Y				
L2034	KAFO PLASTIC MED LAT ROTAT CNTRL CSTM FAB	Prosthetics & Orthotics	Y				
L2036	KAFO FULL PLASTIC DOUBLE UPRIGHT CSTM FAB	Prosthetics & Orthotics	Y				
L2037	KAFO FULL PLASTIC SINGLE UPRIGHT CUSTOM FAB	Prosthetics & Orthotics	Y				
L2038	KAFO FULL PLASTIC MX-AXIS ANKLE CUSTOM FAB	Prosthetics & Orthotics	Y				
L2090	HKAFO UNI TORSION CABLE BALL BEAR CSTM	Prosthetics & Orthotics	Y				
L2106	AFO FX ORTHOTIC TIB FX CAST THERMOPLSTC CSTM FAB	Prosthetics & Orthotics	Y				
L2108	AFO FX ORTHOTIC TIB FX CAST ORTHOSIS CSTM FAB	Prosthetics & Orthotics	Y				
L2126	KAFO FEM FX CAST ORTHOTIC THERMOPLSTC CSTM FAB	Prosthetics & Orthotics	Y				
L2128	KAFO FX ORTHOTIC FEM FX CAST ORTHOSIS CSTM FAB	Prosthetics & Orthotics	Y				
L2350	ADD LOW EXTREM PROSTHETIC TYPE SOCKT MOLD PT MDL	Prosthetics & Orthotics	Y				
L2525	ADD LW EXTRM ISCH M-L BRIM MOLD PT MDL	Prosthetics & Orthotics	Y				
L2627	ADD LW EXT PELV PLSTC MOLD PT MDL HIP JNT AND CABLES	Prosthetics & Orthotics	Y				
L2628	ADD LW EXT PELV METL FRME RECIP HIP JNT AND CABLES	Prosthetics & Orthotics	Y				
L2999	LOWER EXTREMITY ORTHOSES NOT OTHERWISE SPECIFIED	Prosthetics & Orthotics	Y				
L3900	WHFO DYN FLEXOR HINGE WRST/FNGR DRIVEN CSTM FAB	Prosthetics & Orthotics	Y				
L3901	WHFO DYN FLEXOR HINGE CABLE DRIVEN CSTM FAB	Prosthetics & Orthotics	Y				
L3904	WHFO EXTERNAL POWERED ELECTRIC CUSTOM FABRICATED	Prosthetics & Orthotics	Y				
L3999	UPPER LIMB ORTHOSIS NOT OTHERWISE SPECIFIED	Prosthetics & Orthotics	Y				
L4631	AFO WALK BOOT TYP ROCKR BOTTM ANT TIB SHELL CSTM	Prosthetics & Orthotics	Y				
L5050	ANKLE SYMES MOLDED SOCKET SACH FOOT	Prosthetics & Orthotics	Y				
L5060	ANK SYMES METL FRME MOLD LEATHER SOCKT ARTIC ANK	Prosthetics & Orthotics	Y				
L5100	BELOW KNEE MOLDED SOCKET SHIN SACH FOOT	Prosthetics & Orthotics	Y				
L5105	BELOW KNEE PLSTC SOCKT JNT AND THIGH LACER SACH FOOT	Prosthetics & Orthotics	Y				
L5150	KNEE DISRTC MOLD SOCKT EXT KNEE JNT SHIN SACH FT	Prosthetics & Orthotics	Y				
L5160	KNEE DISARTIC MOLD SOCKT BENT KNEE EXT KNEE JNT	Prosthetics & Orthotics	Y				
L5200	ABOVE KNEE MOLD SOCKET 1 AXIS CONSTANT FRICTION	Prosthetics & Orthotics	Y				
L5210	ABOVE KNEE SHRT PROSTH NO KNEE JNT NO ANK JNT EA	Prosthetics & Orthotics	Y				
L5220	ABOVE KNEE SHORT PROSTH W/ARTIC ANK/FOOT DYN	Prosthetics & Orthotics	Y				
L5230	ABOVE KNEE PROXIMAL FEM FOCAL DEFIC SACH FOOT	Prosthetics & Orthotics	Y				
L5250	HIP DISARTIC CANADIAN TYPE MOLD SOCKT HIP JNT	Prosthetics & Orthotics	Y				
L5270	HIP DISRTC TILT TABLE MOLD SCKT LOCK HIP JNT	Prosthetics & Orthotics	Y				
L5280	HEMIPELVECT CANADIAN TYPE MOLD SOCKT HIP JNT	Prosthetics & Orthotics	Y				
L5301	BELOW KNEE MOLD SOCKET SHIN SACH FT ENDOSKEL SYS	Prosthetics & Orthotics	Y				
L5312	KNEE DISARTIC MOLD SOCKET 1 AXIS KNEE SACH FOOT	Prosthetics & Orthotics	Y				
L5321	ABOVE KNEE OPEN END SACH FT ENDO SYS 1 AXIS KNEE	Prosthetics & Orthotics	Y				
L5331	JOINT SINGLE AXIS KNEE SACH FOOT	Prosthetics & Orthotics	Y				
L5341	SINGLE AXIS KNEE SACH FOOT	Prosthetics & Orthotics	Y				
L5500	INIT BELOW KNEE PTB SOCKET NON-ALIGN DIR FORMED	Prosthetics & Orthotics	Y				
L5505	INIT ABVE KNEE-DISARTC ISCH LEVL SOCKT NON-ALIGN	Prosthetics & Orthotics	Y				
L5510	PREP BELOW KNEE PTB SOCKET NON-ALIGN MOLD MODEL	Prosthetics & Orthotics	Y				
L5520	PREP BK PTB SCKT NON-ALIGN THERMOPLSTC/ Equal to DIR FORM	Prosthetics & Orthotics	Y				
L5530	PREP BK PTB SCKT NON-ALIGN THERMOPLSTC/ Equal to MOLD MDL	Prosthetics & Orthotics	Y				
L5535	PREP BELOW KNEE PTB NON-ALIGN PRFAB ADJ OPEN END	Prosthetics & Orthotics	Y				
L5540	PREP BK PTB SCKT NON-ALIGN LAMINATD SCKT MOLD MDL	Prosthetics & Orthotics	Y				
L5560	PREP AK-DISRTC ISCH LEVL PLASTER SOCKET MOLD MDL	Prosthetics & Orthotics	Y				
L5570	PREP AK-DISRTC ISCH LEVL THERMOPLSTC/Equal to DIR FORMED	Prosthetics & Orthotics	Y				
L5580	PREP AK DISARTIC NON-ALIGN THERMOPLSTC/ Equal to MOLD MDL	Prosthetics & Orthotics	Y				
L5585	PREP AK-DISARTC NON-ALIGN PRFAB ADJ OPN END SCKT	Prosthetics & Orthotics	Y				
L5590	PREP AK-DISARTIC NON-ALIGN LAMINATED SOCKET MOLD	Prosthetics & Orthotics	Y				
L5595	PREP HIP DISARTIC-HEMIPELVECT THERMOPLSTC/ Equal to MOLD	Prosthetics & Orthotics	Y				
L5600	PREP HIP DISARTIC-HEMIPELVECT LAMINATD SCKT MOLD	Prosthetics & Orthotics	Y				
L5610	ADD LW EXTRM ENDO SYS ABVE KNEE HYDRACADENCE SYS	Prosthetics & Orthotics	Y				
L5611	ADD LW EXTRM ENDO AK-DISRTC 4-BAR LINK W/FRICT	Prosthetics & Orthotics	Y				
L5613	ADD LOW EXTRM ENDO AK-DISRTC 4-BAR W/HYDRAULIC	Prosthetics & Orthotics	Y				
L5614	ADD LOW EXT EXOSKEL SYS AK-DISARTC 4-BAR PNEUMAT	Prosthetics & Orthotics	Y				
L5616	ADD LOW EXTRM ENDO AK UNIVERSAL MXPLX SYS FRICT	Prosthetics & Orthotics	Y				
L5639	ADDITION LOWER EXTREMITY BELOW KNEE WOOD SOCKET	Prosthetics & Orthotics	Y				
L5643	ADD LW EXT HIP DISARTIC FLX INNR SOCKT EXT FRAME	Prosthetics & Orthotics	Y				
L5649	ADD LW EXT ISCHIAL CONTAINMENT/NARROW M-L SOCKET	Prosthetics & Orthotics	Y				
L5651	ADD LW EXT ABVE KNEE FLXIBLE INNR SOCKT EXT FRME	Prosthetics & Orthotics	Y				
L5681	ADD LW EXT BK/AK CST INS CNGL/ATYP TRAUM AMP INIT	Prosthetics & Orthotics	Y				
L5683	ADD LW EXTR BK/AK CST FAB NO CNGN/TRAUM AMP INIT	Prosthetics & Orthotics	Y				
L5700	REPLACEMENT SOCKET BELOW KNEE BK MOLDED PT MODEL	Prosthetics & Orthotics	Y				
L5701	REPL SOCKT ABOVE KNEE/KNEE DISARTIC W/ATTCH PLAT	Prosthetics & Orthotics	Y				
L5702	REPLCMT SOCKT HIP DISARTIC W/HIP JNT MOLD PT MDL	Prosthetics & Orthotics	Y				
L5703	ANKLE SYMES MOLD PT MODEL SACH FOOT REPL ONLY	Prosthetics & Orthotics	Y				
L5705	CUSTOM SHAPED PROTECTIVE COVER ABOVE KNEE AK	Prosthetics & Orthotics	Y				
L5706	CUSTOM SHAPED PROTECTIVE COVER KNEE DISARTIC	Prosthetics & Orthotics	Y				
L5707	CUSTOM SHAPED PROTECTIVE COVER HIP DISARTIC	Prosthetics & Orthotics	Y				
L5718	ADD EXOSKEL KNEE-SHIN POLYCNTRC FRICT SWING CNTRL	Prosthetics & Orthotics	Y				
L5722	ADD EXOSKEL KNEE-SHIN PNEUMAT SWING FRICT CNTRL	Prosthetics & Orthotics	Y				
L5724	ADD EXOSKEL KNEE-SHIN FLUID SWING PHASE CNTRL	Prosthetics & Orthotics	Y				
L5726	ADD EXOSKEL KNEE-SHIN EXT JOINT FL SWING CNTRL	Prosthetics & Orthotics	Y				
L5728	ADD EXOSKEL KNEE-SHIN FLUID SWING AND STANCE CNTRL	Prosthetics & Orthotics	Y				
L5780	ADD EXOSKEL KNEE-SHIN PNEUMAT/HYDRA PNEUMAT CNTRL	Prosthetics & Orthotics	Y				
L5781	ADD LW LIMB PROS RESIDUL LIMB VOL MGMT SYS	Prosthetics & Orthotics	Y				
L5782	ADD LW LIMB PROS RESIDUL LIMB MGMT SYS HEVY DUTY	Prosthetics & Orthotics	Y				
L5783	ADD LWR EXT USER ADJ MECH RES LIMB VOL MGMT SYS	Prosthetics & Orthotics	Y				
L5795	ADD EXOSKEL SYSTEM HIP DISARTIC ULTRA-LGHT MATL	Prosthetics & Orthotics	Y				
L5814	ADD ENDOSKEL KNEE-SHIN HYDRAULIC SWING MECH LOCK	Prosthetics & Orthotics	Y				
L5816	ADD ENDOSKEL KNEE-SHIN MECH STANCE PHASE LOCK	Prosthetics & Orthotics	Y				
L5822	ADD ENDOSKEL KNEE-SHIN PNEUMAT SWING FRICT CNTRL	Prosthetics & Orthotics	Y				
L5824	ADD ENDOSKEL KNEE-SHIN FLUID SWING PHASE CNTRL	Prosthetics & Orthotics	Y				
L5826	ADD ENDO KNEE-SHIN HYDRAUL SWNG MIN HI ACTV FRME	Prosthetics & Orthotics	Y				
L5827	ENDO KNEE SHIN SINGLE AXIS	Prosthetics & Orthotics	Y				
L5828	ADD ENDO KNEE-SHIN FL SWING AND STANCE PHASE CNTRL	Prosthetics & Orthotics	Y				
L5830	ADD ENDOSKEL KNEE-SHIN PNEUMAT/SWING PHASE CNTRL	Prosthetics & Orthotics	Y				
L5840	ADD ENDO KNEE-SHIN 4-BAR LINK/MX-AXIAL PNEUMAT	Prosthetics & Orthotics	Y				
L5841	ADD ENDOSKEL KNEE-SHIN SYS PNEU SW and ST PH CTRL	Prosthetics & Orthotics	Y				
L5845	ADD ENDOSKEL KNEE-SHIN STANCE FLX FEATUR ADJ	Prosthetics & Orthotics	Y				
L5848	ADD ENDOSKEL KNEE-SHIN SYS FLUID STANCE EXTENSN	Prosthetics & Orthotics	Y				
L5856	ADD LOW EXT PROS KNEE-SHIN SYS SWING AND STANCE PHSE	Prosthetics & Orthotics	Y				
L5857	ADD LOW EXT PROS KNEE-SHIN SYS SWING PHASE ONLY	Prosthetics & Orthotics	Y				
L5858	ADD LW EXT PROS KNEE SHIN SYS STANCE PHASE ONLY	Prosthetics & Orthotics	Y				
L5859	ADD LOW EXT PROS KN-SHIN PROG FLX EXT ANY MOTOR	Prosthetics & Orthotics	Y				
L5930	ADD ENDOSKEL SYSTEM HIGH ACTV KNEE CONTROL FRAME	Prosthetics & Orthotics	Y				
L5961	ADD ENDO SYS POLYCNTRC HIP JOINT ROTATION CNTRL	Prosthetics & Orthotics	Y				
L5964	ADD ENDOSKEL AK FLEXIBLE PROTVE OUTR SURF COVER	Prosthetics & Orthotics	Y				
L5966	ADD ENDO HIP DISRTC FLXIBL PROTVE OUTR SURF COVR	Prosthetics & Orthotics	Y				
L5968	ADD LW LIMB PROSTH MX-AXIAL ANK W/SWING PHASE	Prosthetics & Orthotics	Y				
L5969	ADDITION ENDOSKELETAL ANKLE-FOOT/ANK PWR ASSIST	Prosthetics & Orthotics	Y				
L5973	ENDOSKEL ANK FOOT SYS MICRPROCSS CONTROL PWR SRC	Prosthetics & Orthotics	Y				
L5979	ALL LW EXTRM PRSTH MX-AXL ANK DYN RSPN FT 1 PECE	Prosthetics & Orthotics	Y				
L5980	ALL LOWER EXTREMITY PROSTHESES FLEX-FOOT SYSTEM	Prosthetics & Orthotics	Y				
L5981	ALL LOWER EXTREM PROSTH FLEX-WALK SYSTEM/EQUAL	Prosthetics & Orthotics	Y				
L5987	ALL LW XTRM PRSTH SHNK FT SYS W/VRTCL LOAD PYLN	Prosthetics & Orthotics	Y				
L5988	ADD LW LIMB PROSTH VERTCL SHOCK RDUC PYLN FEATUR	Prosthetics & Orthotics	Y				
L5990	ADD LOW EXTREM PROSTH USER ADJUSTBLE HEEL HT	Prosthetics & Orthotics	Y				
L5999	LOWER EXTREMITY PROSTHESIS NOS	Prosthetics & Orthotics	Y				
L6000	PARTIAL HAND THUMB REMAINING	Prosthetics & Orthotics	Y				
L6010	PARTIAL HAND LITTLE AND OR RING FINGER REMAINING	Prosthetics & Orthotics	Y				
L6020	PARTIAL HAND NO FINGER REMAINING	Prosthetics & Orthotics	Y				
L6026	TRANSCARPAL MC PART HAND DISARTICULATION PROS	Prosthetics & Orthotics	Y				
L6050	WRST DISARTIC MOLD SOCKET FLEX ELB HNG TRICP PAD	Prosthetics & Orthotics	Y				
L6055	WRST DISARTIC MOLD SOCKT W/XPNDABLE INTERFCE	Prosthetics & Orthotics	Y				
L6100	BELW ELB MOLD SOCKT FLXIBLE ELB HINGE TRICP PAD	Prosthetics & Orthotics	Y				
L6110	BELOW ELBOW MOLDED SOCKET	Prosthetics & Orthotics	Y				
L6120	BELW ELB MOLD DBL WALL SCKT STEP-UP HNG 1/2 CUFF	Prosthetics & Orthotics	Y				
L6130	BELW ELB STUMP ACTVATD LOCK HINGE HALF CUFF	Prosthetics & Orthotics	Y				
L6200	ELB DISARTC MOLD SOCKT OUTSIDE LOCK HINGE FORARM	Prosthetics & Orthotics	Y				
L6205	ELB DISARTC MOLD SCKT W/XPND INTRFCE LOCK FORARM	Prosthetics & Orthotics	Y				
L6250	ABVE ELB MOLD DBL WALL SCKT INTRL LCK ELB FORARM	Prosthetics & Orthotics	Y				
L6300	SHLDR DISARTIC MOLD SOCKET INTRL LOCK ELB FORARM	Prosthetics & Orthotics	Y				
L6310	SHOULDER DISARTIC PASSIVE REST COMPLETE PROSTH	Prosthetics & Orthotics	Y				
L6320	SHOULDER DISART PASSIVE REST SHOULDER CAP ONLY	Prosthetics & Orthotics	Y				
L6360	INTERSCAPULAR THOR PASSIVE REST CMPL PROSTH	Prosthetics & Orthotics	Y				
L6370	INTERSCAPULAR THOR PASSIVE REST SHLDR CAP ONLY	Prosthetics & Orthotics	Y				
L6400	BE MOLD SCKT ENDOSKEL SYS W/SFT PROSTH TISS SHAP	Prosthetics & Orthotics	Y				
L6450	ELB DISRTC MOLD SCKT ENDOSKEL W/SFT PROSTH TISS	Prosthetics & Orthotics	Y				
L6500	ABVE ELB MOLD SCKT ENDOSKEL W/SFT PROSTH TISS	Prosthetics & Orthotics	Y				
L6550	SHLDR DISRTC MOLD SCKT ENDOSKEL W/SFT PROS TISS	Prosthetics & Orthotics	Y				
L6570	INTRSCAP THOR MOLD SCKT ENDOSKEL W/SFT PROS TISS	Prosthetics & Orthotics	Y				
L6580	PREP WRST DISRTC/BELW ELB 1 WALL PLSTC SCKT MOLD	Prosthetics & Orthotics	Y				
L6582	PREP WRST DISRTC/BELW ELB 1 WALL SCKT DIR FORMED	Prosthetics & Orthotics	Y				
L6584	PREP ELB DISRTC/ABVE ELB 1 WALL PLSTC SOCKT MOLD	Prosthetics & Orthotics	Y				
L6586	PREP ELB DISRTC/ABVE ELB 1 WALL SOCKT DIR FORMED	Prosthetics & Orthotics	Y				
L6588	PREP SHLDR DISRTC THOR 1 WALL PLSTC SCKT MOLD	Prosthetics & Orthotics	Y				
L6590	PREP SHLDR DISRTC THOR 1 WALL SOCKET DIR FORM	Prosthetics & Orthotics	Y				
L6621	UP EXTREM PROS ADD FLEXION/EXTENSION WRIST	Prosthetics & Orthotics	Y				
L6624	UPPER EXTREMITY ADD FLX/EXT ROTATION WRIST UNIT	Prosthetics & Orthotics	Y				
L6638	UP EXT ADD PROS ELEC LOCK ONLY W/MNL PWR ELB	Prosthetics & Orthotics	Y				
L6646	UP EXT ADD SHLDR JNT MX PSTN W/BDY/EXT PWR SYS	Prosthetics & Orthotics	Y				
L6648	UP EXTREM ADD SHLDR LOCK MECH EXT PWR ACTUATOR	Prosthetics & Orthotics	Y				
L6693	UPPER EXTREM ADD LOCK ELB FORARM COUNTERBALANCE	Prosthetics & Orthotics	Y				
L6696	ADD UP EXT PROS ELB CSTM CNGN/TRAUMAT AMP INIT	Prosthetics & Orthotics	Y				
L6697	ADD UP EXT PROS ELB CSTM NOT CNGN/TRAUM AMP INIT	Prosthetics & Orthotics	Y				
L6700	UE ADD EXT POWER MYOEL	Prosthetics & Orthotics	Y				
L6707	TERMINAL DEVICE HOOK MECH VOLUNTARY CLOSING	Prosthetics & Orthotics	Y				
L6708	TERMINAL DEVICE HAND MECH VOLUNTARY OPENING	Prosthetics & Orthotics	Y				
L6709	TERMINAL DEVICE HAND MECH VOLUNTARY CLOSING	Prosthetics & Orthotics	Y				
L6712	TERM DVC HOOK MECH VOL CLOS ANY MATL ANY SZ PED	Prosthetics & Orthotics	Y				
L6713	TERM DVC HAND MECH VOL OPN ANY MATL ANY SIZE PED	Prosthetics & Orthotics	Y				
L6715	TERM DEV MX ARTIC DIGIT W/MOTORS INIT ISSUE/REPL	Prosthetics & Orthotics	Y				
L6721	TERM DEVC HOOK/HND HVY-DUTY MECH VOL OPN ANY SZ	Prosthetics & Orthotics	Y				
L6722	TERM DEVC HOOK/HAND HVY-DUTY MECH VOL CLOS	Prosthetics & Orthotics	Y				
L6880	ELEC HAND SWTCH/MYOELEC CNTRL INDEP ARTC DIG MTR	Prosthetics & Orthotics	Y				
L6881	AUTOMATIC GRASP ADD UPPER LIMB ELEC PROSTH DEVC	Prosthetics & Orthotics	Y				
L6882	MICRPRROCSS CNTRL FEATUR ADD UP LIMB PROSTH DEVC	Prosthetics & Orthotics	Y				
L6900	HAND REST PART HAND W/GLOVE THUMB/1 FNGR REMAIN	Prosthetics & Orthotics	Y				
L6905	HAND REST PART HAND W/GLOVE MX FNGR REMAIN	Prosthetics & Orthotics	Y				
L6910	HAND REST PART HAND W/GLOVE NO FNGR REMAIN	Prosthetics & Orthotics	Y				
L6920	WRST DISARTIC OTTO BOCK/ Equal to SWTCH CNTRL TERM DEVICE	Prosthetics & Orthotics	Y				
L6925	WRST DISARTIC OTTO BOCK/ Equal to MYOELEC CNTRL TERM DEVC	Prosthetics & Orthotics	Y				
L6930	BELOW ELBOW OTTO BOCK/ Equal to SWITCH CNTRL TERM DEVICE	Prosthetics & Orthotics	Y				
L6935	BELOW ELBOW OTTO BOCK/ Equal to MYOELEC CNTRL TERM DEVICE	Prosthetics & Orthotics	Y				
L6940	ELBOW DISARTIC OTTO BOCK/ Equal to SWITCH CNTRL TERM DEVC	Prosthetics & Orthotics	Y				
L6945	ELB DISARTIC OTTO BOCK/ Equal to MYOELEC CNTRL TERM DEVC	Prosthetics & Orthotics	Y				
L6950	ABOVE ELBOW OTTO BOCK/ Equal to SWITCH CNTRL TERM DEVC	Prosthetics & Orthotics	Y				
L6955	ABOVE ELBOW OTTO BOCK/ Equal to MYOELEC CNTRL TERM DEVC	Prosthetics & Orthotics	Y				
L6960	SHLDR DISARTIC OTTO BOCK/ Equal to SWTCH CNTRL TERM DEVC	Prosthetics & Orthotics	Y				
L6965	SHOULDR DISARTIC OTTO BOCK/ Equal to MYOELEC CNTRL TERM	Prosthetics & Orthotics	Y				
L6970	INTERSCAP-THOR OTTO BOCK/ Equal to SWTCH CNTRL TERM DEVC	Prosthetics & Orthotics	Y				
L6975	INTERSCAP-THOR OTTO BOCK/ Equal to MYOELEC CNTRL TERM DVC	Prosthetics & Orthotics	Y				
L7007	ELECTRIC HAND SWITCH/MYOELECTRIC CONTROL ADULT	Prosthetics & Orthotics	Y				
L7008	ELECTRIC HAND SWITCH/MYOELECTRIC CNTRL PEDIATRIC	Prosthetics & Orthotics	Y				
L7009	ELECTRIC HOOK SWITCH/MYOELECTRIC CONTROL ADULT	Prosthetics & Orthotics	Y				
L7040	PREHENSILE ACTUATOR SWITCH CONTROLLED	Prosthetics & Orthotics	Y				
L7045	ELEC HOOK SWITCH/MYOELECTRIC CONTOL PEDIATRIC	Prosthetics & Orthotics	Y				
L7170	ELECTRONIC ELBOW HOSMER/EQUAL SWITCH CONTROLLED	Prosthetics & Orthotics	Y				
L7180	ELEC ELB MICROPRC SEQENTIAL CNTRL ELB AND TERM DEVC	Prosthetics & Orthotics	Y				
L7181	ELEC ELB MICROPRC SIMULTAN CNTRL ELB AND TERM DEVC	Prosthetics & Orthotics	Y				
L7185	ELEC ELB ADOLES VRITY VILLAGE/EQUAL SWITCH CNTRL	Prosthetics & Orthotics	Y				
L7186	ELEC ELB CHILD VRITY VILLAGE/EQUAL SWITCH CNTRL	Prosthetics & Orthotics	Y				
L7190	ELEC ELB ADOLES VRITY VILLAGE/ Equal to MYOELEC CNTRL	Prosthetics & Orthotics	Y				
L7191	ELEC ELB CHLD VRITY VILL/ Equal to MYOELECTRNICALY CNTRL	Prosthetics & Orthotics	Y				
L7259	ELECTRONIC WRIST ROTATOR ANY TYPE	Prosthetics & Orthotics	Y				
L7406	ADD TO UPP EXTR USER ADJ MEC	Prosthetics & Orthotics	Y				
L7499	UPPER EXTREMITY PROSTHESIS NOS	Prosthetics & Orthotics	Y				
L8033	NIPPLE PROSTH CSTM FAB REUSABL ANY MATL ANY T EA	Prosthetics & Orthotics	Y				
L8039	BREAST PROSTHESIS NOT OTHERWISE SPECIFIED	Prosthetics & Orthotics	Y				
L8499	UNLISTED PROC MISCELLANEOUS PROSTHETIC SERVICES	Prosthetics & Orthotics	Y				
L8608	MISC EXT COMP SPL ACSS FOR ARGUS II RET PROS SYS	Prosthetics & Orthotics	Y				
L8614	COCHLEAR DEVICE INCLUDES ALL INT AND EXT COMPONENTS	Prosthetics & Orthotics	Y				
L8678	ELECTRICAL STIM SUP EXT USE W/I NEUROSTIM PER MO	Prosthetics & Orthotics	Y				
L8692	AUDITORY OSSEOINTEGRATED DEV EXT SOUND BODY WORN	Prosthetics & Orthotics	Y				
L8699	PROSTHETIC IMPLANT NOT OTHERWISE SPECIFIED	Prosthetics & Orthotics	Y				
L8701	PWR UE ROM AST DVC ELB WR HAND 1 DBL UP CUS FAB	Prosthetics & Orthotics	Y				
L8702	PWR UE ROM AST DVC ELBO WR H FINGER 1 DBL UP CUS	Prosthetics & Orthotics	Y				
S1040	CRANIAL REMOLDING ORTHOTIC PED RIGID CUSTOM FAB	Prosthetics & Orthotics	Y				
76965	US GUIDANCE INTERSTITIAL RADIOELMENT APPLICATION	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77011	CT GUIDANCE STEREOTACTIC LOCALIZATION	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77014	CT GUIDANCE RADIATION THERAPY FLDS PLACEMENT	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77261	THER RAD TX PLNNING SMPL	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77262	THER RAD TX PLNNING INTRM	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77263	THER RAD TX PLNNING CPLX	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77280	THER RAD SIMULAJ-AIDED FIELD SETTING SIMPLE	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77285	THER RAD SIMULAJ-AIDED FIELD SETTING INTERMED	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77290	THER RAD SIMULAJ-AIDED FIELD SETTING COMPLEX	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77293	RESPIRATORY MOTION MANAGEMENT SIMULATION	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77295	3-D RADIOTHERAPY PLAN DOSE-VOLUME HISTOGRAMS	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77299	UNLISTD PRCDRE THRPTC RDLGY CLINICAL TX PLANNING	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77300	BASIC RADIATION DOSIMETRY CALCULATION	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77301	NTSTY MODUL RADTHX PLN DOSE-VOL HISTOS	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77306	TELETHX ISODOSE PLN SMPL W/DOSIMETRY CALCULATION	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77307	TELETHX ISODOSE PLN CPLX W/BASIC DOSIMETRY	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77316	BRACHYTX ISODOSE PLN SMPL W/DOSIMETRY CAL	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77317	BRACHYTX ISODOSE PLN INTERMED W/DOSIMETRY CAL	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77318	BRACHYTX ISODOSE PLN CPLX W/DOSIMETRY CAL	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77321	SPEC TELETHX PORT PLN PARTS HEMIBDY TOT BDY	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77331	SPEC DOSIM ONLY PRESCRIBED TREATING PHYS	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77332	TX DEVICES DESIGN AND CONSTRUCTION SIMPLE	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77333	TX DEVICES DESIGN AND CONSTRUCTION INTERMEDIATE	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77334	TX DEVICES DESIGN AND CONSTRUCTION COMPLEX	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77336	CONTINUING MEDICAL PHYSICS CONSLTJ PR WK	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77338	MLC IMRT DESIGN AND CONSTRUCTION PER IMRT PLAN	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77370	SPEC MEDICAL RADJ PHYSICS CONSLTJ	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77371	RADIATION DELIVERY STEREOTACTIC CRANIAL COBALT	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient except for OH.		Y
77372	RADIATION DELIVERY STEREOTACTIC CRANIAL LINEAR	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient except for OH, WA. OH, WA pediatrics direct request to the healthplan.		Y
77373	STEREOTACTIC BODY RADIATION DELIVERY	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient except for OH, WA. OH, WA pediatrics direct request to the healthplan.		Y

77385	INTENSITY MODULATED RADIATION TX DLVR SIMPLE	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient except for OH.		Y
77386	INTENSITY MODULATED RADIATION TX DLVR COMPLEX	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient except for OH.		Y
77387	GUIDANCE FOR LOCLZJ TARGET VOL FOR RADJ TX DLVR	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77401	RADIATION TX DELIVERY SUPERFICIAL & ORTHO VOLTA	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77402	RADIATION TREATMENT DELIVERY 1 MEV PLUS SIMPLE	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77407	RADIATION TX DELIVERY 1 MEV EQUAL TO GT INTERMEDIATE	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77412	RADIATION TREATMENT DELIVERY 1 MEV EQ OVER COMPLEX	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient except for OH.		Y
77417	THERAPEUTIC RADIOLOGY PORT IMAGE(S)	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77423	HI ENRGY NEUTRON RADTN TX DLVR 1 OR GRT ISOCENTER	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77427	RADIATION TREATMENT MANAGEMENT 5 TREATMENTS	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77431	RADIATION THERAPY MGMT 1/2 FRACTIONS ONLY	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77432	STERETCTC RADIATION TX MANAGEMENT CRANIAL LESION	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77435	STEREOTACTIC BODY RADIATION MANAGEMENT	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77470	SPECIAL TREATMENT PROCEDURE	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77499	UNLISTED PROCEDURE THRPTC RADIOLOGY TX MGMT	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77520	PROTON TX DELIVERY SIMPLE W O COMPENSATION	Radiation Therapy & Radio Surgery	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
77522	PROTON TX DELIVERY SIMPLE W COMPENSATION	Radiation Therapy & Radio Surgery	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
77523	PROTON TX DELIVERY INTERMEDIATE	Radiation Therapy & Radio Surgery	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
77525	PROTON TX DELIVERY COMPLEX	Radiation Therapy & Radio Surgery	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
77750	INFSJ/INSTLJ RADIOELMNT SLN 3 MO FOLLOW-UP CARE	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77761	INTRACAVITARY RADIATION SOURCE APPLIC SIMPLE	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77762	INTRACAVITARY RADIATION SOURCE APPLIC INTERMED	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77763	INTRACAVITARY RADIATION SOURCE APPLIC COMPLEX	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77767	HDR RDNCL SKN SURF BRACHYTX LES LT 2CM/1 CHAN	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77768	HDR RDNCLDE SKN SRFCE BRCHYTX LESION >2CM & 2CHAN/MLTPLE LESION	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77770	HDR RDNCL NTRSTL/INTRCAV BRACHYTX 1 CHANNEL	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77771	HDR RDNCL NTRSTL/INTRCAV BRACHYTX 2-12 CHANNEL	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77772	HDR RDNCL NTRSTL/INTRCAV BRACHYTX GT 12 CHANNELS	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77778	INTERSTITIAL RADIATION SOURCE APPLIC COMPLEX	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77789	SURFACE APPLIC LOW DOSE RATE RADIONUCLIDE SOURCE	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
77790	SUPERVISION HANDLING LOADING RADIATION SOURCE	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
A9513	LUTETIUM LU 177 DOTATATE THERAPEUTIC 1 MCI	Radiation Therapy & Radio Surgery	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
A9543	YTTRIUM Y-90 IBRITUMOMAB TIUXETAN TX TO 40 MCI	Radiation Therapy & Radio Surgery	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
A9590	IODINE I-131 IOBENGUANE, THERAPEUTIC, I MILLICURIE	Radiation Therapy & Radio Surgery	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
A9600	STRONTIUM SR-89 CHLORID THERAPEUTIC PER MCI	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient except for MS. MS pediatrics direct request to the healthplan.		Y
A9604	SAMARIUM SM-153 LEXIDRONAM TX DOSE TO 150 MCI	Radiation Therapy & Radio Surgery	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
A9606	RADIUM RA-223 DICHLORIDE THERAPEUTIC PER UCI	Radiation Therapy & Radio Surgery	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
G0339	IMAGE GUID ROBOTIC ACCEL BASE SRS CMPL TX 1 SESS	Radiation Therapy & Radio Surgery	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
G0340	IMAGE GUID ROBOTIC ACCL SRS FRAC TX LES 2-5 SESS	Radiation Therapy & Radio Surgery	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
G6001	ULTRASONIC GUID PLACEMENT RADIATION TX FIELDS	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
G6002	STEREOSCOPIC X-RAY GUID LOCALIZ TRG VOL DEL RT	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
G6003	RAD TX DEL 2 TX AREA PORT PL OPP PORTS:TO 5 MEV	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
G6004	RAD TX DEL 1 TX AREA PORT PL OPP PORTS: 6-10 MEV	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
G6005	RAD TX DEL 1 TX AREA PORT PL OPP PORTS: 11-19 ME	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
G6006	RAD TX DEL 1 TX AREA PORT PL OPP PORTS: 20 ME OR GRT	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
G6007	RT DEL 2 SEP AR 3 OR GRT PT 1 TX AR MX BLKS:TO 5 MEV	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
G6008	RT DEL 2 SEP AR 3 OR GRT PT 1 TX AR MX BLKS:6-10 MEV	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
G6009	RT DEL 2 SEP AR 3 OR GRT PT 1 TX AR MX BLKS:11-19 MEV	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
G6010	RT DEL 2 SEP AR 3 OR GRT PT 1 TX AR MX BLKS:20 MEV OR GRT	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
G6011	RAD TX DEL 3 OR GRT SEP TX AR CSTM BLOCKING; TO 5 MEV	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
G6012	RAD TX DEL 3 OR GRT SEP TX AR CSTM BLOCKING; 6-10 MEV	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
G6013	RAD TX DEL 3 OR GRT SEP TX AR CSTM BLOCKING;11-19 MEV	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
G6014	RAD TX DEL 3 OR GRT SEP TX AR CSTM BLOCKING;20 MEV OR GRT	Radiation Therapy & Radio Surgery	~	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Adults with non cancer diagnosis or Inpatient, direct request to the Healthplan. For Pediatrics, no PA Required for outpatient.		Y
G6015	INTENSITY MODULATED TX DEL 1 MX FLDS PER TX SESS	Radiation Therapy & Radio Surgery	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
G6016	COMP-BASED BEAM MOD TX DEL I PLNO TX 3 OVER HR SESS	Radiation Therapy & Radio Surgery	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
G6017	INTRA-FRAC LOC AND TRACKING TARGET PT M EA FRAC TX	Radiation Therapy & Radio Surgery	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
95805	MLT SLEEP LATENCY MAINT OF WAKEFULNESS TSTG	Sleep Studies	Y				
95807	SLEEP STD REC VNTJ RESPIR ECG HRT RATE AND O2 ATTN	Sleep Studies	Y				
95808	POLYSOM ANY AGE SLEEP STAGE 1-3 ADDL PARAM ATTND	Sleep Studies	Y				
95810	POLYSOM 6 OR GRT YRS SLEEP 4 OR GRT ADDL PARAM ATTND	Sleep Studies	Y				
95811	POLYSOM 6 OR GRT YRS SLEEP W CPAP 4 OR GRT ADDL PARAM ATT	Sleep Studies	Y				
32850	DONOR PNEUMONECTOMY(S), INCL COLD PRESERV, FROM CADAVER DONOR	Transplants/Gene Therapy	Y				
32851	LUNG TRANSPL, SINGLE, W O CARDIOPULM BYPASS	Transplants/Gene Therapy	Y				
32852	LUNG TRANSPL, SINGLE, W CARDIOPULM BYPASS	Transplants/Gene Therapy	Y				
32853	LUNG TRANSPLANT 2 W O CARDIOPULMONARY BYPASS	Transplants/Gene Therapy	Y				
32854	LUNG TRANSPLANT 2 W CARDIOPULMONARY BYPASS	Transplants/Gene Therapy	Y				
32855	BKBENCH PREPJ CADAVER DONOR LUNG ALLOGRAFT UNI	Transplants/Gene Therapy	Y				
32856	BKBENCH PREPJ CADAVER DONOR LUNG ALLOGRAFT BI	Transplants/Gene Therapy	Y				
33929	REMOVAL TOTAL RPLCMT HEART SYS FOR HEART TRNSPL	Transplants/Gene Therapy	Y				
33930	DONOR CARDIECTOMY - PNEUMONECTOMY	Transplants/Gene Therapy	Y				
33933	BKBENCH PREPJ CADAVER DONOR HEART LUNG ALLOGRAFT	Transplants/Gene Therapy	Y				
33935	HEART-LUNG TRNSPL W/RECIPIENT CARDIECTOMY-PNUMEC	Transplants/Gene Therapy	Y				
33940	DONOR CARDIECTOMY	Transplants/Gene Therapy	Y				
33944	BKBENCH PREPJ CADAVER DONOR HEART ALLOGRAFT	Transplants/Gene Therapy	Y				
33945	HEART TRANSPLANT W/WO RECIPIENT CARDIECTOMY	Transplants/Gene Therapy	Y				
33995	INSJ PERQ VAD W/RS AND I R HEART VENOUS ACCESS ONLY	Transplants/Gene Therapy	Y				
38204	MGMT RCP HEMATOP PROGENITOR CELL DONOR AND ACQUISJ	Transplants/Gene Therapy	Y				
38205	BLD-DRV HEMATOP PROGEN CELL HRVG TRNSPLJ ALGNC	Transplants/Gene Therapy	Y				
38206	BLD-DRV HEMATOPTC PROGEN CELL HRVSTG TRNSPL AUTO	Transplants/Gene Therapy	Y				
38207	TRNSPL PREPJ HEMATOP PROGEN CELLS CRYOPRSRV STOR	Transplants/Gene Therapy	Y				
38208	TRNSPL PREP HEMATOP PROGEN THAW PREV HRV PER DNR	Transplants/Gene Therapy	Y				
38209	TRNSP PREP HMATOP PROG THAW PREV HRV WSH PER DNR	Transplants/Gene Therapy	Y				
38210	TRNSPL PREPJ HEMATOP PROGEN DEPLJ IN HRV T-CELL	Transplants/Gene Therapy	Y				
38211	TRNSPL PREPJ HEMATOP PROGEN TUM CELL DEPLJ	Transplants/Gene Therapy	Y				
38212	TRNSPL PREPJ HEMATOP PROGEN RED BLD CELL RMVL	Transplants/Gene Therapy	Y				
38213	TRNSPL PREPJ HEMATOP PROGEN PLTLT DEPLJ	Transplants/Gene Therapy	Y				
38214	TRNSPL PREPJ HEMATOP PROGEN PLSM VOL DEPLJ	Transplants/Gene Therapy	Y				
38215	TRNSPL PREPJ HEMATOP PROGEN CONCENTRATION PLSM	Transplants/Gene Therapy	Y				
38225	CAR-T THERAPY HRVG BLD DRV T LMPHCYT PR DAY	Transplants/Gene Therapy	Y				
38226	CAR-T THERAPY PREPJ BLD DRV T LMPHCYT F/TRNS	Transplants/Gene Therapy	Y				
38227	CAR-T THERAPY RECEIPT and PREP CAR-T CELLS F/ADMN	Transplants/Gene Therapy	Y				
38228	CAR-T THERAPY AUTOLOGOUS CELL ADMINISTRATION	Transplants/Gene Therapy	Y				
38230	BONE MARROW HARVEST TRANSPLANTATION ALLOGENEIC	Transplants/Gene Therapy	Y				
38232	BONE MARROW HARVEST TRANSPLANTATION AUTOLOGOUS	Transplants/Gene Therapy	Y				
38240	TRNSPLJ ALLOGENEIC HEMATOPOIETIC CELLS PER DONOR	Transplants/Gene Therapy	Y				
38241	TRNSPLJ AUTOLOGOUS HEMATOPOIETIC CELLS PER DONOR	Transplants/Gene Therapy	Y				
38242	ALLOGENEIC LYMPHOCYTE INFUSIONS	Transplants/Gene Therapy	Y				
38243	TRNSPLJ HEMATOPOIETIC CELL BOOST	Transplants/Gene Therapy	Y				
44132	DONOR ENTERECTOMY OPEN CADAVER DONOR	Transplants/Gene Therapy	Y				
44133	DONOR ENTERECTOMY OPEN LIVING DONOR	Transplants/Gene Therapy	Y				
44135	INTESTINAL ALLOTRANSPLANTATION; CADAVER DONOR	Transplants/Gene Therapy	Y				
44136	INTESTINAL ALLOTRANSPLANTATION; LIVING DONOR	Transplants/Gene Therapy	Y				
44137	RMVL TRNSPLED INTESTINAL ALLOGRAFT COMPL	Transplants/Gene Therapy	Y				
44715	BKBENCH PREP CADAVER LIVING DONOR INTESTINE	Transplants/Gene Therapy	Y				
44720	BKBENCH RCNSTJ INT ALGRFT VEN ANAST EA	Transplants/Gene Therapy	Y				
44721	BKBENCH RCNSTJ INT ALGRFT ARTL ANAST EA	Transplants/Gene Therapy	Y				
47133	DONOR HEPATECTOMY CADAVER DONOR	Transplants/Gene Therapy	Y				
47135	LVR ALTRNSPLJ ORTHOTOPIC PRTL WHL DON ANY AGE	Transplants/Gene Therapy	Y				
47140	DONOR HEPATECTOMY LIVING DONOR SEG II AND III	Transplants/Gene Therapy	Y				
47141	DONOR HEPATECTOMY LIVING DONOR SEG II III AND IV	Transplants/Gene Therapy	Y				
47142	DONOR HEPATECTOMY LIVING DONOR SEG V VI VII AND VI	Transplants/Gene Therapy	Y				
47143	BKBENCH PREP CADAVER DONOR	Transplants/Gene Therapy	Y				
47144	BKBENCH PREPJ CADAVER WHOLE LIVER GRF I AND IV VII	Transplants/Gene Therapy	Y				
47145	BKBENCH PREPN CADAVER DONOR WHL LVR GRF I AND V VI	Transplants/Gene Therapy	Y				
47146	BKBENCH RCNSTJ LVR GRF VENOUS ANAST EA	Transplants/Gene Therapy	Y				
47147	BKBENCH RCNSTJ LVR GRF ARTL ANAST EA	Transplants/Gene Therapy	Y				
48160	PANCREATECTOMY W TRNSPLJ PANCREAS ISLET CELLS	Transplants/Gene Therapy	Y				
48550	DONOR PANCREATECTOMY DUODENAL SGM TRANSPLANT	Transplants/Gene Therapy	Y				
48551	BKBENCH PREPJ CADAVER DONOR PANCREAS ALLOGRAFT	Transplants/Gene Therapy	Y				
48552	BKBENCH RCNSTN CDVR PNCRS ALGRFT VEN ANAST EA	Transplants/Gene Therapy	Y				
48554	TRANSPLANTATION PANCREATIC ALLOGRAFT	Transplants/Gene Therapy	Y				
48556	RMVL TRANSPLANTED PANCREATIC ALLOGRAFT	Transplants/Gene Therapy	Y				
50300	DONOR NEPHRECTOMY CADAVER DONOR UNI BILATERAL	Transplants/Gene Therapy	Y				
50320	DONOR NEPHRECTOMY OPEN LIVING DONOR	Transplants/Gene Therapy	Y				
50323	BKBENCH PREPJ CADAVER DONOR RENAL ALLOGRAFT	Transplants/Gene Therapy	Y				
50325	BKBENCH PREPJ LIVING RENAL DONOR ALLOGRAFT	Transplants/Gene Therapy	Y				
50327	BKBENCH RCNSTJ RENAL ALGRFT VENOUS ANAST EA	Transplants/Gene Therapy	Y				
50328	BKBENCH RCNSTJ RENAL ALLOGRAFT ARTERIAL ANAST EA	Transplants/Gene Therapy	Y				
50329	BKBENCH RCNSTJ ALGRFT URETERAL ANAST EA	Transplants/Gene Therapy	Y				
50340	RECIPIENT NEPHRECTOMY SEPARATE PROCEDURE	Transplants/Gene Therapy	Y				
50360	RENAL ALTRNSPLJ IMPLTJ GRF W O RCP NEPHRECTOMY	Transplants/Gene Therapy	Y				
50365	RENAL ALTRNSPLJ IMPLTJ GRF W RCP NEPHRECTOMY	Transplants/Gene Therapy	Y				
50370	RMVL TRNSPLED RENAL ALLOGRAFT	Transplants/Gene Therapy	Y				
50380	RENAL AUTOTRNSPLJ REIMPLANTATION KIDNEY	Transplants/Gene Therapy	Y				
81560	TRNSPLJ PED LVR AND BWL MES CD154 PLUS T CLL WHL PRPH BLD	Transplants/Gene Therapy	Y				
0584T	PERCUTANEOUS ISLET CELL TRANSPLANT	Transplants/Gene Therapy	Y				
0585T	LAPAROSCOPIC ISLET CELL TRANSPLANT	Transplants/Gene Therapy	Y				
0586T	OPEN ISLET CELL TRANSPLANT	Transplants/Gene Therapy	Y				
J1411	INJ, HEMGENIX, PER TX DOSE	Transplants/Gene Therapy	Y				
J1412	INJECTION VALOCTOCOGENE ROXAPARVOVEC-RVOX PER ML	Transplants/Gene Therapy	Y				
J1413	INJ DELANDISTROGENE MOXEPARVOVEC-ROKL PER THR D	Transplants/Gene Therapy	Y				
J1414	INJ, FIDANACOGENE ELAPARVOVECDZKT, PER THERAPEUTIC DOSE	Transplants/Gene Therapy	Y				
J2326	INJECTION NUSINERSEN 0.1 MG	Transplants/Gene Therapy	Y				
J3391	INJ, ATIDARSAGENE AUTOTEMCEL, PER TREATMENT	Transplants/Gene Therapy	Y				
J3392	INJ, EXAGAMGLOGENE AUTOTEMCEL, PER TREATMENT	Transplants/Gene Therapy	Y				
J3393	INJ, BETIBEGLOGENE AUTOTEMCEL, PER TREATMENT	Transplants/Gene Therapy	Y				
J3394	INJ, LOVOTIBEGLOGENE AUTOTEMCEL, PER TREATMENT	Transplants/Gene Therapy	Y				
J3398	INJECTION VORETIGENE NEPARVOVEC-RZYL 1 B VEC G	Transplants/Gene Therapy	Y				
J3399	INJECTION, ONASEMNOGENE ABEPARVOVEC, PER TX, UP TO 5X10	Transplants/Gene Therapy	Y				
J3401	BEREMAGENE GEPERPAVEC-SVDT, PER 0.1 ML	Transplants/Gene Therapy	Y				
J9029	IVES INSTAL NADOFARAGN FIRADENOVC-VNCG PER THR D	Transplants/Gene Therapy	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
Q2041	KTE-C19 TO 200 M A ANTI-CD19 CAR POS T CE P TD	Transplants/Gene Therapy	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics or non-cancer diagnosis direct request to the healthplan.		Y
Q2042	TISAGENLECLEUCEL TO 600 M CAR-POS VI T CE PER TD	Transplants/Gene Therapy	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics or non-cancer diagnosis direct request to the healthplan.		Y
Q2043	SIPULEUCEL-T AUTO CD54 PLUS	Transplants/Gene Therapy	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics or non-cancer diagnosis direct request to the healthplan.		Y
Q2053	BREXUCABTAGENE CAR POST	Transplants/Gene Therapy	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics or non-cancer diagnosis direct request to the healthplan.		Y
Q2054	LM GT OR EQUAL TO 110 MIL AUTOL ANTI-CD19 CAR-POS VIABL T	Transplants/Gene Therapy	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics or non-cancer diagnosis direct request to the healthplan.		Y
Q2055	IDECABTAGENE VICL 460MIL AUTO BCMA CAR PLUS T LEUKAPH	Transplants/Gene Therapy	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics or non-cancer diagnosis direct request to the healthplan.		Y
Q2056	CILTACABTAGENE AUTOLEUCEL TO 100 M BCMA PER TX D	Transplants/Gene Therapy	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics or non-cancer diagnosis direct request to the healthplan.		Y
Q2057	AFAMITRESGENE AUTOLEUCEL, INCLDNG LEUKAPHERESIS & DOSE PRPRTN PRCDRS, PER THRPTC DOSE	Transplants/Gene Therapy	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
Q2058	OBECABTAGENE CAR POS T	Transplants/Gene Therapy	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with cancer diagnosis direct request to Evolent. For Pediatrics, inpatient, or non-cancer diagnosis direct request to the healthplan.		Y
S2053	TRANSPLANTATION SMALL INTESTINE AND LIVER ALLOGRAFTS	Transplants/Gene Therapy	Y				
S2054	TRANSPLANTATION OF MULTIVISCERAL ORGANS	Transplants/Gene Therapy	Y				
S2055	HARVEST DONOR MX-VISCERAL ORGAN; CADVER DONOR	Transplants/Gene Therapy	Y				
S2060	LOBAR LUNG TRANSPLANTATION	Transplants/Gene Therapy	Y				
S2061	DONOR LOBECTOMY FOR TRANSPLANTATION LIVING DONOR	Transplants/Gene Therapy	Y				
S2065	SIMULTANEOUS PANCREAS KIDNEY TRANSPLANTATION	Transplants/Gene Therapy	Y				
S2107	ADOPTIVE IMMUNOTHERAPY PER COURSE OF TREATMENT	Transplants/Gene Therapy	Y				
S2140	CORD BLOOD HARVESTING TRANSPLANTATION ALLOGENEIC	Transplants/Gene Therapy	Y				
S2142	CORD BLD-DERIVED STEM-CELL TPLNT ALLOGENEIC	Transplants/Gene Therapy	Y				
S2150	BN MARROW BLD DERIVD STEM CELLS HARV TPLNT AND COMP	Transplants/Gene Therapy	Y				
S2152	SOLID ORGAN; TRANSPLANTATION AND RELATED COMP	Transplants/Gene Therapy	Y				
A0430	AMB SERVICE CONVNTION AIR SRVC TRANSPORT 1 WAY FIXED WING	Transportation Services	Y				
A0431	AMB SERVICE CONVNTION AIR SRVC TRANSPORT 1 WAY ROTARY WING	Transportation Services	Y				
S9960	AMB SERVICE AIR NONEMERGENCY 1 WAY FIXED WING	Transportation Services	Y				
S9961	AMB SERVICE AIR NONEMERGENCY 1 WAY ROTARY WING	Transportation Services	Y				
17999	UNLISTED PX SKIN MUC MEMBRANE AND SUBQ TISSUE	Unlisted/Miscellaneous	Y				
19499	UNLISTED PROCEDURE BREAST	Unlisted/Miscellaneous	Y				
21089	UNLISTED MAXILLOFACIAL PROSTHETIC PROCEDURE	Unlisted/Miscellaneous	Y				
21299	UNLISTED CRANIOFACIAL AND MAXILLOFACIAL PROCEDURE	Unlisted/Miscellaneous	Y				
22899	UNLISTED PROCEDURE SPINE	Unlisted/Miscellaneous	Y				
22999	UNLISTED PX ABDOMEN MUSCULOSKELETAL SYSTEM	Unlisted/Miscellaneous	Y				
23929	UNLISTED PROCEDURE SHOULDER	Unlisted/Miscellaneous	Y				
26989	UNLISTED PROCEDURE HANDS FINGERS	Unlisted/Miscellaneous	Y				
27299	UNLISTED PROCEDURE PELVIS HIP JOINT	Unlisted/Miscellaneous	Y				
29999	UNLISTED PROCEDURE ARTHROSCOPY	Unlisted/Miscellaneous	Y				
30999	UNLISTED PROCEDURE NOSE	Unlisted/Miscellaneous	Y				
37501	UNLISTED VASCULAR ENDOSCOPY PROCEDURE	Unlisted/Miscellaneous	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Adults send request to Evolent. For Pediatrics, direct requests to the healthplan.	Y	
37799	UNLISTED PROCEDURE VASCULAR SURGERY	Unlisted/Miscellaneous	Y				
38129	UNLISTED LAPAROSCOPY PROCEDURE SPLEEN	Unlisted/Miscellaneous	Y				
38589	UNLISTED LAPAROSCOPY PX LYMPHATIC SYSTEM	Unlisted/Miscellaneous	Y				
38999	UNLISTED PROCEDURE HEMIC OR LYMPHATIC SYSTEM	Unlisted/Miscellaneous	Y				
39499	UNLISTED PROCEDURE MEDIASTINUM	Unlisted/Miscellaneous	Y				
39599	UNLISTED PROCEDURE DIAPHRAGM	Unlisted/Miscellaneous	Y				
40799	UNLISTED PROCEDURE LIPS	Unlisted/Miscellaneous	Y				
41599	UNLISTED PROCEDURE TONGUE FLOOR MOUTH	Unlisted/Miscellaneous	Y				
42299	UNLISTED PROCEDURE PALATE UVULA	Unlisted/Miscellaneous	Y				
43499	UNLISTED PROCEDURE ESOPHAGUS	Unlisted/Miscellaneous	Y				
43659	UNLISTED LAPAROSCOPIC PROCEDURE STOMACH	Unlisted/Miscellaneous	Y				
43999	UNLISTED PROCEDURE STOMACH	Unlisted/Miscellaneous	Y				
45399	UNLISTED PROCEDURE COLON	Unlisted/Miscellaneous	Y				
47579	UNLISTED LAPAROSCOPY PROCEDURE BILIARY TRACT	Unlisted/Miscellaneous	Y				
47999	UNLISTED PROCEDURE BILIARY TRACT	Unlisted/Miscellaneous	Y				
49999	UNLISTD PROCEDURE ABDOMEN PERITONEUM & OMENTUM	Unlisted/Miscellaneous	Y				
54699	UNLISTED LAPAROSCOPY PROCEDURE TESTIS	Unlisted/Miscellaneous	Y				
55559	UNLISTED LAPROSCOPY PROCEDURE SPERMATIC CORD	Unlisted/Miscellaneous	Y				
55899	UNLISTED PROCEDURE MALE GENITAL SYSTEM	Unlisted/Miscellaneous	Y				
58578	UNLISTED LAPAROSCOPY PROCEDURE UTERUS	Unlisted/Miscellaneous	Y				
58679	UNLISTED LAPAROSCOPY PROCEDURE OVIDUCT OVARY	Unlisted/Miscellaneous	Y				
58999	UNLISTED PX FEMALE GENITAL SYSTEM NONOBSTETRICAL	Unlisted/Miscellaneous	Y				
60699	UNLISTED PROCEDURE ENDOCRINE SYSTEM	Unlisted/Miscellaneous	Y				
64999	UNLISTED PROCEDURE NERVOUS SYSTEM	Unlisted/Miscellaneous	Y				
67299	UNLISTED PROCEDURE POSTERIOR SEGMENT	Unlisted/Miscellaneous	Y				
68899	UNLISTED PROCEDURE LACRIMAL SYSTEM	Unlisted/Miscellaneous	Y				
77399	UNLIS MEDICAL RADJ DOSIM TX DEV SPEC SVCS	Unlisted/Miscellaneous	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with		Y
77799	UNLISTED PROCEDURE CLINICAL BRACHYTHERAPY	Unlisted/Miscellaneous	Y	Y~	~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults with		Y
87797	IADNA NOS DIRECT PROBE TQ EACH ORGANISM	Unlisted/Miscellaneous	Y				
87798	IADNA NOS AMPLIFIED PROBE TQ EACH ORGANISM	Unlisted/Miscellaneous	Y				
87799	IADNA NOS QUANTIFICATION EACH ORGANISM	Unlisted/Miscellaneous	Y				
87899	IAADIADOO NOT OTHERWISE SPECIFIED	Unlisted/Miscellaneous	Y				
88299	UNLISTED CYTOGENETIC STUDY	Unlisted/Miscellaneous	Y				
88399	UNLISTED SURGICAL PATHOLOGY PROCEDURE	Unlisted/Miscellaneous	Y				
93799	UNLISTED CARDIOVASCULAR SERVICE PROCEDURE	Unlisted/Miscellaneous	Y				
95999	UNLIS NEUROLOGICAL NEUROMUSCULAR DX PX	Unlisted/Miscellaneous	Y				
96549	UNLISTED CHEMOTHERAPY PROCEDURE	Unlisted/Miscellaneous	Y				
97039	UNLIST MODALITY SPEC TYPE AND TIME CONSTANT ATTEND	Unlisted/Miscellaneous	Y		PA Required after 12 visits per calendar year for PT/OT/ST.		
97139	UNLISTED THERAPEUTIC PROCEDURE SPECIFY	Unlisted/Miscellaneous	Y		PA Required after 12 visits per calendar year for PT/OT/ST.		
97799	UNLISTED PHYSICAL MEDICINE/REHAB SERVICE/PROC	Unlisted/Miscellaneous	Y				
99499	UNLISTED EVALUATION AND MANAGEMENT SERVICE	Unlisted/Miscellaneous	Y				
99600	UNLISTED HOME VISIT SERVICE PROCEDURE	Unlisted/Miscellaneous	Y				
0705T	REM TX AMBLYOPIA TCH SPRT MIN 18 TRAING HR EA 30	Unlisted/Miscellaneous	Y				
0708T	INTRADERMAL CANCER IMMNTX PREP AND 1ST INJECTION	Unlisted/Miscellaneous	Y				
0709T	INTRADERMAL CANCER IMMNTX EACH ADDL INJECTION	Unlisted/Miscellaneous	Y				
A0999	UNLISTED AMBULANCE SERVICE	Unlisted/Miscellaneous	Y				
A4421	OSTOMY SUPPLY; MISCELLANEOUS	Unlisted/Miscellaneous	Y				

46909	SUTURE N. NYLY 3/0DA-14MM/22	1231A0B2Ecollection	1				
46910	SUTURE N. NYLY 3/0DA-14MM/22	1231A0B2Ecollection	1				
46911	TONGUE TIE DIVISION, BY THE CLAMPED AND CUT METHOD	1231A0B2Ecollection	1				
46912	TONGUE TIE DIVISION, BY THE CLAMPED AND CUT METHOD	1231A0B2Ecollection	1				
46913	TONGUE TIE DIVISION, BY THE CLAMPED AND CUT METHOD	1231A0B2Ecollection	1	2	Tongue ties in same personnel with Severe Low Hemoglobin unspecifiedcause Anemia in the Mother, left		1
46914	SPINAL CUT DOWN OR CLAMPED TO CUT TIES	1231A0B2Ecollection	1				
46915	SPINAL MALLEABLE CHAIN SUPPLY OR ACCESSORY PART	1231A0B2Ecollection	1				
46916	SPINAL MALLEABLE CHAIN	1231A0B2Ecollection	1				
46917	SUTURE COLL PROPHOSPHATE, SEDATIVE TREATMENT OVER 28DA	1231A0B2Ecollection	1				
46918	SUTURE COLL PROPHOSPHATE, SEDATIVE TREATMENT OVER 28DA	1231A0B2Ecollection	1				
46919	SUTURE SPECIAL EQUIPMENT SPECIAL SERVICE	1231A0B2Ecollection	1				
46920	SUTURE OF LIP OR FACE OR PERIO OR ORAL CAVITY REQUIRING A GA	1231A0B2Ecollection	1				
46921	SUTURE OF LIP OR FACE OR PERIO OR ORAL CAVITY REQUIRING A GA	1231A0B2Ecollection	1				
46922	SUTURE NON-EMERGENT SPECIAL NOT OVERNIGHT CLEANING	1231A0B2Ecollection	1				
46923	SUTURE NON-EMERGENT SPECIAL NOT OVERNIGHT CLEANING	1231A0B2Ecollection	1				
47100	SPIN. SUTURE TIME REDUCTION IN OVERNIGHT TIME FRAME	1231A0B2Ecollection	1				
47101	SPIN. SUTURE TIME REDUCTION IN OVERNIGHT TIME FRAME	1231A0B2Ecollection	1				
46912	SUTURE OVERNIGHT SPECIAL NOT OVERNIGHT CLEANING	1231A0B2Ecollection	1				
46913	SUTURE OVERNIGHT SPECIAL NOT OVERNIGHT CLEANING	1231A0B2Ecollection	1				
46914	SPINAL SUTURE TIE OR CUT OVER OVER FOR NOT OVERNIGHT	1231A0B2Ecollection	1				
46915	SPINAL SUTURE TIE OR CUT OVER OVER FOR NOT OVERNIGHT	1231A0B2Ecollection	1				
46916	SPINAL SUTURE TIE OR CUT OVER OVER FOR NOT OVERNIGHT	1231A0B2Ecollection	1				
46917	SPINAL SUTURE TIE OR CUT OVER OVER FOR NOT OVERNIGHT	1231A0B2Ecollection	1				
46918	SPINAL SUTURE TIE OR CUT OVER OVER FOR NOT OVERNIGHT	1231A0B2Ecollection	1				
46919	SPINAL SUTURE TIE OR CUT OVER OVER FOR NOT OVERNIGHT	1231A0B2Ecollection	1				
46920	SPINAL, LIMB REPLACEMENT, SERVICE REPORTED, NOT	1231A0B2Ecollection	1				
46921	SPINAL, LIMB REPLACEMENT, SERVICE REPORTED, NOT	1231A0B2Ecollection	1				
46922	SPINAL, FUSION FOR SCOLIOSIS, SERVICE, NOT OVERNIGHT	1231A0B2Ecollection	1				
46923	SPINAL, FUSION FOR SCOLIOSIS, SERVICE, NOT OVERNIGHT	1231A0B2Ecollection	1				
52001	SUTURE SPECIAL NOT OVERNIGHT SPECIAL	1231A0B2Ecollection	1				
52002	SUTURE SPECIAL NOT OVERNIGHT SPECIAL	1231A0B2Ecollection	1				
52003	SUTURE CLAVICLE FRACTURE, NOT OVERNIGHT OR OVERNIGHT	1231A0B2Ecollection	1				
52004	SUTURE CLAVICLE FRACTURE, NOT OVERNIGHT	1231A0B2Ecollection	1				
52005	SUTURE CLAVICLE FRACTURE, NOT OVERNIGHT	1231A0B2Ecollection	1				
52006	SUTURE CLAVICLE FRACTURE, NOT OVERNIGHT	1231A0B2Ecollection	1				
52007	SUTURE CLAVICLE FRACTURE, NOT OVERNIGHT	1231A0B2Ecollection	1				
52008	SUTURE CLAVICLE FRACTURE, NOT OVERNIGHT	1231A0B2Ecollection	1				
52009	SUTURE CLAVICLE FRACTURE, NOT OVERNIGHT	1231A0B2Ecollection	1				

KENTUCKY CODE/BENEFIT EXCEPTIONS Effective Q3, 2025

Authorization is required for:
All Medical, Behavioral Health Inpatient Services (Acute, Scheduled, Rehabilitation, LTAC)
Select Medical Outpatient Services performed at a Hospital (Provider Type 01) ; Select Behavioral Health Services
PA Disclaimers Ky Passport
- Healthcare Administered Drugs: Call Provider Services at: (800) 578-0775 / Fax: 844-802-1406 -
-Advanced Imaging: Fax requests to: (877) 731-7218
- Transplants: Phone: (855) 714-2415 / Fax: (877) 813-1206
- Select Cardiology and Oncology Authorizations (for adults over 18 only): New Century Health (NCH): Phone: (888) 999-7713 / Website: https://my.newcenturyhealth.com. For Drugs with Not otherwise specified code, please refer to NCH Code listing to determine if it is a code reviewed by NCH. If requesting a drug for delivery by a pharmacy, please visit kyportal.medimpact.com for authorization information.
- Non-Par Providers/Facilities: PA is required for office visits, procedures, labs, diagnostic studies, and inpatient stays except for: Emergency and Urgent Care claims.
- Maternity: Authorization is required for NVD > 3 days (auth required on day 4) and C section > 5 days (auth required on day 6).
Authorization is required for baby if baby stays > 5 days; Authorization is required for ANY NICU admission regardless of length of stay (Authorization via Progeny).
- Home Healthcare Services
Medicaid: Skilled Nursing Visits: Requires authorization after initial evaluation plus six (6) visits per calendar year per member.
- Therapy: Outpatient Therapy Services: Physical, Occupational and Speech Therapy : office,outpatient and home settings
Requires authorization after initial evaluation plus twenty (20) visits per calendar year per member / Authorization is reviewed in visits (4 Units = 1 visit) / UM reviews by visit and not by individual modality
- Sleep Study: Prior auth required except for Home Sleep Study
- EPSDT Special Services (SS)
Codes listed as non-covered or not on DMS fee schedules may be considered for coverage under EPSDT SS and require prior authorization
For coverage of codes, refer to the Kentucky Department of Medicaid Services Fee Schedules at:
Fee Schedules - Cabinet for Health and Family Services (ky.gov)

Code	Description for "Y" Exceptions	Service Category for "Y" Exceptions	Code Notes
90867	THRPTC RPTTV TMS TX INTL W MAP MOTR THRESHLD DLVRY AND MNGMNT	Behavioral/Mental Health, Alcohol-Chemical Dependency	No PA for Ky Medicaid
90868	THERAP REPETITIVE TMS TX SUBSEQ DELIVERY AND MNG	Behavioral/Mental Health, Alcohol-Chemical Dependency	No PA for Ky Medicaid
90869	REPET TMS TX SUBSEQ MOTR THRESHLD W DLVRY AND MNGMNT	Behavioral/Mental Health, Alcohol-Chemical Dependency	No PA for Ky Medicaid
90870	ELECTROCONVULSIVE THERAPY (ECT)	Behavioral/Mental Health, Alcohol-Chemical Dependency	No PA for Ky Medicaid
H0008	ALCOHOL AND OR DRUG SRVC; SUB-ACUTE DTOX HOSP IP	Behavioral/Mental Health, Alcohol-Chemical Dependency	No PA : Refer to DMS fee schedules for coverage
H0009	ALCOHOL AND OR DRUG SERVICES; ACUTE DTOX HOSP IP	Behavioral/Mental Health, Alcohol-Chemical Dependency	No PA : Refer to DMS fee schedules for coverage

Code	Description for "Y" Exceptions	Service Category for "Y" Exceptions	Code Notes
H0010	ALCOHOL AND / DRUG SRVC; SUB-ACUTE DTOX RES PROG IP	Behavioral/Mental Health, Alcohol-Chemical Dependency	No PA : Refer to DMS fee schedules for coverage
H0012	ALCOHOL AND DRUG SRVC; SUB-ACUTE DTOX RES PROG OP	Behavioral/Mental Health, Alcohol-Chemical Dependency	No PA : Refer to DMS fee schedules for coverage
H0013	ALCOHOL AND DRUG SERVICES; ACUTE DTOX RES PROG OP	Behavioral/Mental Health, Alcohol-Chemical Dependency	No PA : Refer to DMS fee schedules for coverage
H0014	ALCOHOL AND OR DRUG SERVICES; AMB DETOXIFICATION	Behavioral/Mental Health, Alcohol-Chemical Dependency	No PA : Refer to DMS fee schedules for coverage
H0016	ALCOHOL AND OR DRUG SERVICES; MEDICAL SOMATIC	Behavioral/Mental Health, Alcohol-Chemical Dependency	No PA : Refer to DMS fee schedules for coverage
H0017	BEHAVIORAL HEALTH; RES W O ROOM AND BOARD PER DIEM	Behavioral/Mental Health, Alcohol-Chemical Dependency	No PA : Refer to DMS fee schedules for coverage
H0018	BHVAL HEALTH; SHORT-TERM RES W O ROOM AND BOARD-DIEM	Behavioral/Mental Health, Alcohol-Chemical Dependency	No PA : Refer to DMS fee schedules for coverage
H0019	BHVAL HEALTH; LONG-TERM RES W/O ROOM AND BOARD-DIEM	Behavioral/Mental Health, Alcohol-Chemical Dependency	No PA : Refer to DMS fee schedules for coverage
H0046	MENTAL HEALTH SERVICES NOT OTHERWISE SPECIFIED	Behavioral/Mental Health, Alcohol-Chemical Dependency	No PA : Refer to DMS fee schedules for coverage
H2013	PSYCHIATRIC HEALTH FACILITY SERVICE PER DIEM	Behavioral/Mental Health, Alcohol-Chemical Dependency	No PA : Refer to DMS fee schedules for coverage
H2016	COMP COMMUNITY SUPPORT SERVICES PER DIEM	Behavioral/Mental Health, Alcohol-Chemical Dependency	No PA : Refer to DMS fee schedules for coverage
H2018	PSYCHOSOCIAL REHABILITATION SERVICES PER DIEM	Behavioral/Mental Health, Alcohol-Chemical Dependency	No PA : Refer to DMS fee schedules for coverage
H2019	THERAPEUTIC BEHAVIORAL SERVICES PER 15 MINUTES	Behavioral/Mental Health, Alcohol-Chemical Dependency	No PA : Refer to DMS fee schedules for coverage
0373T	ADAPT BHV TX PRTCL MODIFICAJ EA 15 MIN TECH TIME	Behavioral/Mental Health, Alcohol-Chemical Dependency	No PA : Refer to DMS fee schedules for coverage
S0201	PARTIAL HOSPITLZTN SERVICES UNDER 24 HR PER DIEM	Behavioral/Mental Health, Alcohol-Chemical Dependency	No PA : Refer to DMS fee schedules for coverage
A4206	SYRINGE WITH NEEDLE STERILE 1 CC OR LESS EACH	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4207	SYRINGE WITH NEEDLE STERILE 2 CC EACH	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4208	SYRINGE WITH NEEDLE STERILE 3 CC EACH	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4209	SYRINGE WITH NEEDLE STERILE 5 CC OR GREATER EACH	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4230	INFUS SET EXT INSULIN PUMP NONNDLE CANNULA TYPE	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4231	INFUSION SET EXTERNAL INSULIN PUMP NEEDLE TYPE	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.

Code	Description for "Y" Exceptions	Service Category for "Y" Exceptions	Code Notes
A4250	URINE TEST OR REAGENT STRIPS OR TABLETS	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4253	BLD GLU TEST/REAGT STRIPS HOME BLD GLU MON-50	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4259	LANCETS PER BOX OF 100	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4310	INSERTION TRAY W/O DRAIN BAG AND W/O CATHETER	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4311	INSRTION TRAY W/O DRN BAG W/CATH 2-WAY LATEX	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4320	IRRIGATION TRAY W/BULB/PISTON SYRINGE ANY PRPOS	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4322	IRRIGATION SYRINGE BULB OR PISTON EACH	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4326	MALE EXT CATH W/INTEGRAL CLCT CHAMB ANY TYPE EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4338	INDWELL CATH; FOLEY TYPE TWO-WAY LATEX W/COAT EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4344	INDWELL CATH FOLEY TYPE TWO-WAY ALL SILCON EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4353	INTERMIT URINARY CATHETER W/INSERTION SUPPLIES	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4356	EXTERNAL URETHRAL CLAMP/COMPRESSION DEVICE EACH	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4357	BEDSID DRN BAG DAY/NGT W/WO ANTI-REFLX DEVC EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4361	OSTOMY FACEPLATE EACH	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4362	SKIN BARRIER; SOLID 4 FOUR OR EQUIVALENT; EACH	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4366	OSTOMY VENT ANY TYPE EACH	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4367	OSTOMY BELT EACH	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4398	OSTOMY IRRIGATION SUPPLY; BAG EACH	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4399	OSTOMY IRRIGATION SUPPLY; CONE/CATH W/WO BRUSH	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4400	OSTOMY IRRIGATION SET	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4402	LUBRICANT, PER OZ	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.

Code	Description for "Y" Exceptions	Service Category for "Y" Exceptions	Code Notes
A4404	OSTOMY RING EACH	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4416	OSTOMY POUCH CLOSED W/BARRIER ATTCH W/FILTER EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4417	OST POUCH CLO W/BARRIER ATTCH W/BUILT-IN CONVXIT	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4418	OSTOMY POUCH CLOS; W/O BARRIER ATTCH W/FILTER EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4419	OST POUCH CLOS; BARRIER W/NON-LOCK FLNGE W/FLTR	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4420	OSTOMY POUCH CLOS; USE BARRIER W/LOCK FLNGE EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4423	OST POUCH CLOS; BARRIER W/LOCK FLNGE W/FLTR EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4424	OSTOMY POUCH DRAINABLE W/BARRIER ATTCH W/FLTR EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4425	OST POUCH DRNABL; BARR NON-LOCK FLNGE W/FILTR EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4426	OST POUCH DRAINABLE; USE BARRIER W/LOCK FLNGE EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4427	OST POUCH DRNABLE; BARRIER LOCK FLNGE W/FLTR EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4428	OST POUCH URIN EXT BARR W/FAUCET TAP W/VALVE	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4429	OST POUCH URIN BLT-IN CONVXI W/FAUCET TAP VALVE	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4430	OST POUCH URIN EXT BARR BLT-IN CNVX FAUCT VLV EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4431	OST POUCH URIN; W/BARR W/FAUCET TAP W/VALVE EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4432	OST POUCH URIN;BARR NON-LOCK FLNG FAUCT TAP VALV	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4433	OST POUCH URIN; FOR BARR W/LOCKING FLANGE EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4434	OST POUCH URIN; BARR LOCK FLNG FAUCET TAP VALVE	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4435	OST POUCH DRAIN HI OP EXT WEAR BARR W/WO FLTR EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4606	OXYGEN PROBE USE W/OXIMETER DEVICE REPLACEMENT	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4623	TRACHEOSTOMY INNER CANNULA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.

Code	Description for "Y" Exceptions	Service Category for "Y" Exceptions	Code Notes
A4624	TRACHEAL SUCTN CATH TYPE OTH THAN CLOS SYS EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4625	TRACHEOSTOMY CARE KIT FOR NEW TRACHEOSTOMY	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A4626	TRACHEOSTOMY CLEANING BRUSH EACH	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A5051	OSTOMY POUCH CLOSED; WITH BARRIER ATTACHED EACH	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A5052	OSTOMY POUCH CLOSED; WITHOUT BARRIER ATTACHED EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A5053	OSTOMY POUCH CLOSED; FOR USE ON FACEPLATE EACH	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A5054	OSTOMY POUCH CLOSED; USE BARRIER W/FLANGE EACH	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A5055	STOMA CAP	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A5057	OST POUCH DRAINABL EXT WEAR BARR CONVXTY FLTR EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A5061	OSTOMY POUCH DRAINABLE; W/BARRIER ATTACHED EACH	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A5062	OSTOMY POUCH DRAINABLE; WITHOUT BARRIER ATTCH EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A5063	OSTOMY POUCH DRAINABLE; USE BARRIER W/FLANGE EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A5071	OSTOMY POUCH URINARY; WITH BARRIER ATTACHED EACH	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A5072	OSTOMY POUCH URINARY; WITHOUT BARRIER ATTCH EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A5073	OSTOMY POUCH URINARY; USE BARRIER W/FLANGE EACH	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A5081	STOMA PLUG OR SEAL ANY TYPE	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A5082	CONTINENT DEVICE; CATHETER FOR CONTINENT STOMA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A5093	OSTOMY ACCESSORY; CONVEX INSERT	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A5102	BEDSIDE DRAIN BOTTLE W/WO TUBING RIGD/XPNDABLE EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A5114	LEG STRAP; FOAM/FABRIC REPLACEMENT ONLY PER SET	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee
A5121	SKIN BARRIER; SOLID 6 X 6 OR EQUIVALENT EACH	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.

Code	Description for "Y" Exceptions	Service Category for "Y" Exceptions	Code Notes
A5122	SKIN BARRIER; SOLID 8 X 8 OR EQUIVALENT EACH	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A5126	ADHESIVE OR NON-ADHESIVE; DISK OR FOAM PAD	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A5131	APPLINC CLNR INCONT AND OSTOMY APPLINCS PER 16 OZ	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A5500	DIAB ONLY FIT CSTM PREP AND SPL SHOE MX DNSITY INSRT	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A5501	DIAB ONLY FIT CSTM PREP AND SPL SHOE MOLD PTS FT	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A5503	DIAB ONLY MOD SHOE/CSTM MOLD ROLLER/ROCKR BOTTOM	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A5504	DIAB ONLY MOD SHOE/CSTM MOLD SHOE W/WEDGE SHOE	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A5505	DIAB ONLY MOD SHOE/CSTM MOLD SHOE W/MT BAR SHOE	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A5506	DIAB ONLY MOD SHOE/CSTM MOLD SHOE W/OFF SET HEEL	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A5507	DIAB ONLY NOS MOD SHOE/CSTM MOLD SHOE PER SHOE	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A5508	DIAB ONLY DELUXE FEATURE SHOE/CSTM MOLD SHOE	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A5510	DIAB ONLY DIR FORM COMPRS MOLD PTS FT W/O HEAT	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A5512	FOR DIAB ONLY MX DNSITY INSRT DIR FORMD PRFAB EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A5513	DIA ONLY MX DEN INSRT CSTM FRM MDL PT FT CF EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A6545	GRADIENT COMPRS WRAP NONELAST BK 30-50 MM HG EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A7048	VACUUM DRAINAGE COLLECTION UNIT AND TUBING KIT EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A7522	TRACHEOST/LARYNGECT TUBE STNLESS STEEL/EQUAL EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A7525	TRACHEOSTOMY MASK EACH	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
A7526	TRACHEOSTOMY TUBE COLLAR/HOLDER EACH	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
E0140	WALKER W/TRUNK SUPPORT ADJUSTBLE/FIX HT ANY TYPE	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
E0167	PAIL OR PAN USE W/COMMODE CHAIR REPLACEMENT ONLY	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.

Code	Description for "Y" Exceptions	Service Category for "Y" Exceptions	Code Notes
E0200	HEAT LAMP W/O STAND INCL BULB/INFRARED ELEMENT	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee
E0205	HEAT LAMP W/STAND INCLUDES BULB/INFRARED ELEMENT	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
E0210	ELECTRIC HEAT PAD STANDARD	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
E0215	ELECTRIC HEAT PAD MOIST	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
E0225	HYDROCOLLATOR UNIT INCLUDES PADS	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
E0239	HYDROCOLLATOR UNIT PORTABLE	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
E0275	BED PAN STANDARD METAL OR PLASTIC	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
E0276	BED PAN FRACTURE METAL OR PLASTIC	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
E0325	URINAL; MALE JUG-TYPE ANY MATERIAL	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
E0326	URINAL; FEMALE JUG-TYPE ANY MATERIAL	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
E0480	PERCUSSOR ELECTRIC OR PNEUMATIC HOME MODEL	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
E0570	NEBULIZER WITH COMPRESSOR	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
E0572	AROSL COMPRS ADJSTBL PRSS LGHT DUTY INTERMIT USE	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
E0574	ULTRASONIC/ELEC AROSL GEN W/SMALL VOLUME NEB	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
E0575	NEBULIZER ULTRASONIC LARGE VOLUME	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
E0580	NEBULIZR DURABLE GLASS/AUTOCLAVABLE PLSTC BOTTLE	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
E0585	NEBULIZER WITH COMPRESSOR AND HEATER	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
E0600	RESP SUCTION PUMP HOME MODEL PRTBLE/STATION ELEC	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
E0607	HOME BLOOD GLUCOSE MONITOR	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
E0776	IV POLE	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
E0781	AMB INFUS PUMP 1/MX CHANNL W/ADMN EQP WORN BY PT	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.

Code	Description for "Y" Exceptions	Service Category for "Y" Exceptions	Code Notes
E0935	CONTINUOUS PASSIVE MOT EXERCISE DEVC KNEE ONLY	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
E2100	BLD GLU MONITOR W/INTEGRATED VOICE SYNTHESIZER	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
E2359	PWR WC ACCESSORY GRP 34 SEALED LEAD ACID BATT EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
E2360	PWR WC ACSS 22 NF NON-SEALED LEAD ACID BATTRY EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
E2362	PWR WC ACSS GRP 24 NON-SEALED LEAD ACID BATT EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
E2363	PWR WC ACSS GRP 24 SEALED LEAD ACID BATTRY EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
E2364	PWR WC ACSS U-1 NON-SEALED LEAD ACID BATTRY EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
E2365	PWR WHLCHAIR ACSS U-1 SEALED LEAD ACID BATTRY EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
K0001	STANDARD WHEELCHAIR	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
S8189	TRACHEOSTOMY SUPPLY NOT OTHERWISE CLASSIFIED	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
T4521	ADLT SIZED DISPBL INCONT PROD BRF/DIAPER SM EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
T4522	ADLT SIZED DISPBL INCONT PROD BRF/DIAPER MED EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
T4523	ADLT SIZED DISPBL INCONT PROD BRF/DIAPER LG EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
T4524	ADLT SZD DISPBL INCONT PROD BRF/DIAPER X-LG EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
T4525	ADLT SZD DISPBL INCONT PROD UNDWEAR/PULLON SM EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
T4526	ADLT SZD DISPBL INCONT PROD UNDWEAR MED EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
T4527	ADLT SZD DISPBL INCONT PROD UNDWEAR/PULLON LG EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
T4528	ADLT SZD DISPBL INCONT PROD UNDWEAR XTRA LG EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
T4529	PED SZD DISPBL INCONT PROD BRF/DIAPER SM/MED EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
T4530	PED SZD DISPBL INCONT PROD BRF/DIAPER LG SZ EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
T4531	PED SZD DISPBL INCONT PROD UNDWEAR SM/MED EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.

Code	Description for "Y" Exceptions	Service Category for "Y" Exceptions	Code Notes
T4532	PED SZD DISPBL INCONT PROD UNDWEAR/PULLON LG EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
T4533	YOUTH SIZED DISPBL INCONT PRODUCT BRF/DIAPER EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
T4534	YOUTH SZD DISPBL INCONT PROD UNDWEAR/PULLON EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
T4535	DISPBL LINER/SHIELD/GUARD/PAD/UNDGRMNT INCONT EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
T4541	INCONTINENCE PRODUCT DISPOSABLE UNDPAD LARGE EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
T4542	INCONTINENCE PRODUCT DISPBL UNDPAD SMALL SIZE EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
T4543	ADULT SIZE DISP INCONTINENCE PROD ABOVE XL EA	Durable Medical Equipment (DME)	Prior authorization is required for quantities above limits outlined in state fee schedule.
J1000	INJECTION DEPO-ESTRADIOL CYPIONATE UP TO 5 MG	Healthcare Administered Drugs	Prior authorization required for members under 18 years of age.
J1050	INJECTION MEDROXYPROGESTERONE ACETATE 1 MG	Healthcare Administered Drugs	Prior authorization required for members under 18 years of age.
J1071	INJECTION TESTOSTERONE CYPIONATE 1 MG	Healthcare Administered Drugs	Prior authorization required for members under 18 years of age.
J1072	INJ, TESTOSTERONE CYPIONATE (AZMIRO), 1MG	Healthcare Administered Drugs	Prior authorization required for members under 18 years of age.
J1380	INJECTION ESTRADIOL VALERATE UP TO 10 MG	Healthcare Administered Drugs	Prior authorization required for members under 18 years of age.
J1410	INJECTION ESTROGEN CONJUGATED PER 25 MG	Healthcare Administered Drugs	Prior authorization required for members under 18 years of age.
J1435	INJECTION ESTRONE PER 1 MG	Healthcare Administered Drugs	Prior authorization required for members under 18 years of age.
J2326	INJECTION NUSINERSEN 0.1 MG	Healthcare Administered Drugs	Medicaid: Requests for this drug should be directed to MedImpact (Portal: kyportal.medimpact.com or Phone: 1-844-336-2676 or Fax: 1-858-357-2612)
J3121	INJECTION TESTOSTERONE ENANTHATE 1 MG	Healthcare Administered Drugs	Prior authorization required for members under 18 years of age.
J3399	INJECTION, ONASEMNOGENE ABEPARVOVEC, PER TX, UP TO 5X10	Healthcare Administered Drugs	Medicaid: Requests for this drug should be directed to MedImpact (Portal: kyportal.medimpact.com or Phone: 1-844-336-2676 or Fax: 1-858-357-2612)
J7318	HYALURONAN DERIVATIVE DUROLANE FOR IA INJ 1 MG	Healthcare Administered Drugs	This J code is not covered. Please submit J7321, J7323, or J7324 for medical necessity review.
J7320	HYALURONAN DERIVITIVE GENVISC 850 IA INJ 1 MG	Healthcare Administered Drugs	This J code is not covered. Please submit J7321, J7323, or J7324 for medical necessity review.
J7322	HYALURONAN DERIVATIVE HYMOVIS IA INJ 1 MG	Healthcare Administered Drugs	This J code is not covered. Please submit J7321, J7323, or J7324 for medical necessity review.
J7325	HYALURONAN DERIV SYNVISC SYNVISC-ONE IA INJ 1 MG	Healthcare Administered Drugs	This J code is not covered. Please submit J7321, J7323, or J7324 for medical necessity review.
J7326	HYALURONAN DERIV GEL-ONE INTRA-ARTIC INJ PER DOS	Healthcare Administered Drugs	This J code is not covered. Please submit J7321, J7323, or J7324 for medical necessity review.
J9217	LEUPROLIDE ACETATE 7.5 MG	Healthcare Administered Drugs	Prior authorization required for members under 18 years of age.
S0138	FINASTERIDE 5 MG	Healthcare Administered Drugs	Prior authorization required for members under 18 years of age.
G0159	SERVICES PT HOME HEALTH EST DEL PT MP EA 15 MINS	Home Health Care Services	PA required following 20 visits.

Code	Description for "Y" Exceptions	Service Category for "Y" Exceptions	Code Notes
G0160	SERVICES OT HOME HEALTH EST DEL OT MP EA 15 MINS	Home Health Care Services	PA required following 20 visits.
G0161	SERVICE SLP HH EST DEL SPCH-LANG PATH MP EA 15 M	Home Health Care Services	PA required following 20 visits.
S9128	SPEECH THERAPY IN THE HOME PER DIEM	Home Health Care Services	PA required following 20 visits.
S9129	OCCUPATIONAL THERAPY IN THE HOME PER DIEM	Home Health Care Services	PA required following 20 visits.
S9131	PHYSICAL THERAPY; IN THE HOME PER DIEM	Home Health Care Services	PA required following 20 visits.
T1000	PRIV DUTY/INDEPEND NRS SERVICE LIC UP 15 MIN	Home Health Care Services	Nn PA : Please refer 1 DMS fee schedules for coverage
96125	STANDARDIZED COGNITIVE PERFORMANCE TESTING	Neuropsychological and Psychological Tests	No PA Required
92507	TX SPEECH LANG VOICE COMMN AND AUDITORY PROC IND	Physical, Occupational, and Speech Therapy	PA required after 20 visits per calendar year. Services outlined in SB 111 will not require PA
92508	TX SPEECH LANGUAGE VOICE COMMN AUDITRY 2 OR MORE INDIVL	Physical, Occupational, and Speech Therapy	PA required after 20 visits per calendar year. Services outlined in SB 111 will not require PA
97110	THERAPEUTIC PX 1/> AREAS EACH 15 MIN EXERCISES	Physical, Occupational, and Speech Therapy	PA required after 20 visits per calendar year.
97112	THER PX 1/> AREAS EACH 15 MIN NEUROMUSC REEDUCAN	Physical, Occupational, and Speech Therapy	PA required after 20 visits per calendar year.
97113	THER PX 1 OR MORE AREAS EACH 15 MIN AQUA THRPY W/EXERCSS	Physical, Occupational, and Speech Therapy	PA required after 20 visits per calendar year.
97116	THER PX 1 OR MORE AREAS EA 15 MIN GAIT TRAING W/STAIR	Physical, Occupational, and Speech Therapy	PA required after 20 visits per calendar year.
97124	THER PX 1 OR GT AREAS EACH 15 MINUTES MASSAGE	Physical, Occupational, and Speech Therapy	PA required after 20 visits per calendar year.
97129	THER IVNTJ COG FUNCJ CNTCT 1ST 15 MINUTES	Physical, Occupational, and Speech Therapy	PA required after 20 visits per calendar year. Services outlined in SB 111 will not require PA
97130	THER IVNTN COG FUNCJ CNTCT EA ADDL 15 MINUTES	Physical, Occupational, and Speech Therapy	PA required after 20 visits per calendar year. Services outlined in SB 111 will not require PA
97140	MANUAL THERAPY TQS 1/> REGIONS EACH 15 MINUTES	Physical, Occupational, and Speech Therapy	PA required after 20 visits per calendar year.
97150	THERAPEUTIC PROCEDURES GROUP 2 OR MORE INDVDUALS	Physical, Occupational, and Speech Therapy	PA required after 20 visits per calendar year.
97530	THERAPEUT ACTVITY DIRECT PT CONTACT EACH 15 MIN	Physical, Occupational, and Speech Therapy	PA required after 20 visits per calendar year.
97533	SENSORY INTEGRATIVE TECHNIQUES EACH 15 MINUTES	Physical, Occupational, and Speech Therapy	PA required after 20 visits per calendar year. Services outlined in SB 111 will not require PA
97535	SELF-CARE/HOME MGMT TRAINING EACH 15 MINUTES	Physical, Occupational, and Speech Therapy	PA required after 20 visits per calendar year. Services outlined in SB 111 will not require PA

Code	Description for "Y" Exceptions	Service Category for "Y" Exceptions	Code Notes
97763	ORTHOTICS/PROSTH MGMT &/TRAINNG SBSQ ENCTR 15 MIN	Physical, Occupational, and Speech Therapy	PA required after 20 visits per calendar year.
L0190	CERV MX POST COLLR OCCIP/MAND SUPP ADJ CERV BARS	Prosthetics & Orthotics	PA required above quantity limit: 1 unit per year
L0200	CERV MX POST COLLR OCCIP/MAND ADJ CERV AND THOR EXT	Prosthetics & Orthotics	PA required above quantity limit: 1 unit per year
L0468	TLSO SAGITTAL-CORONAL CONTROL PREFAB CUSTOM FIT	Prosthetics & Orthotics	PA required above quantity limit: 1 unit per year
L0470	TLSO TRIPLANAR POST FRME AND ANT APRON W/STRAP PRFAB	Prosthetics & Orthotics	PA required above quantity limit: 1 unit per year
L0472	TLSO TRIPLANAR HYPREXT RIGD ANT AND LAT FRME PRFAB	Prosthetics & Orthotics	PA required above quantity limit: 1 unit per year
L0492	TLSO THREE RIGID PLASTIC SHELLS PREFABRICATED	Prosthetics & Orthotics	PA required above quantity limit: 1 unit per year
L3030	FOOT INSERT REMOVABLE FORMED PATIENT FOOT EACH	Prosthetics & Orthotics	PA required above quantity limit: 2 units per foot per year
L7364	TWELVE VOLT BATTERY EACH	Prosthetics & Orthotics	PA required above quantity limit: 2 units per year
L7366	BATTERY CHARGER 12 VOLT EACH	Prosthetics & Orthotics	PA required above quantity limit: 1 unit per 4 years
L7368	LITHIUM ION BATTERY CHARGER REPLACEMENT ONLY	Prosthetics & Orthotics	PA required above quantity limit: 1 unit per 4 years
L8000	BREAST PROS MASTECTOMY BRA W/O INTEG PROS FORM	Prosthetics & Orthotics	PA required above quantity limit: 5 units per year
L8001	BREAST PROS MASTECT BRA W/INTEG BREAST FORM UNI	Prosthetics & Orthotics	PA required above quantity limit: 5 units per year
L8002	BREAST PROS MASTECT BRA W/INTEG BREAST FORM BIL	Prosthetics & Orthotics	PA required above quantity limit: 5 units per year
L8020	BREAST PROSTHESIS MASTECTOMY FORM	Prosthetics & Orthotics	PA required above quantity limit: 2 units per year
L8030	BREAST PROSTH SILICONE/EQUAL W/O INTEGRAL ADHES	Prosthetics & Orthotics	PA required above quantity limit: 2 units per year
B4034	ENTERAL FEEDING SUPPLY KIT; SYRINGE FED PER DAY	Unlisted & Miscellaneous	PA required above quantity limit: 1 unit per calendar month
B4036	ENTERAL FEEDING SUPPLY KIT; GRAVITY FED PER DAY	Unlisted & Miscellaneous	PA required above quantity limit: 1 unit per calendar month
B4100	FOOD THICKENER ADMINISTERED ORALLY PER OUNCE	Unlisted & Miscellaneous	PA required above quantity limit: 180 units (oz) per calendar month
B4220	PARENTERAL NUTRITION SUPPLY KIT; PREMIX PER DAY	Unlisted & Miscellaneous	PA required above quantity limit: 1 unit per calendar month
B4222	PARNTRAL NUTRITION SUPPLY KIT; HOME MIX PER DAY	Unlisted & Miscellaneous	PA required above quantity limit: 1 unit per calendar month
B4224	PARENTERAL NUTRITION ADMINISTRATION KIT PER DAY	Unlisted & Miscellaneous	PA required above quantity limit: 1 unit per calendar month
90875			
90876			
90901			
90912			
90913			

Code	Description for "Y" Exceptions	Service Category for "Y" Exceptions	Code Notes
96020			
G2082			Services covered under pharmacy benefit only.
G2083			Services covered under pharmacy benefit only.
S0013			Services covered under pharmacy benefit only.
T4537	INCONTINENCE PRODUCT, PROTECTIVE UNDERPAD, REUSABLE, BED SIZE, EACH		Prior authorization is required for quantities above limits outlined in state fee schedule.
T4540	INCONTINENCE PRODUCT, PROTECTIVE UNDERPAD, REUSABLE, CHAIR SIZE, EACH		Prior authorization is required for quantities above limits outlined in state fee schedule.
T4544	ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, ABOVE EXTRA LARGE, EACH		Prior authorization is required for quantities above limits outlined in state fee schedule.