Yes = PRIOR AUTHORIZATION REQUIRED No = NO PRIOR AUTHORIZATION REQUIRED

** Out of network providers require service pre-auth ALWAYS**

DISCLAIMER: A PRIOR AUTHORIZATION DOES NOT GUARANTEE THAT BENEFITS WILL BE PAID

Effective 01/01/2020 00:00:01

Category	Services	USFHP	TX HIX	LA HIX	TX MA	NM MA	NCHD
Admissions	Inpatient Hospital Admissions	Yes	Yes	Yes	Yes	Yes	No if at Spohn
Admissions	Observation Stay (2 days only)	No	No	No	No	No	No if at Spohn
Admissions	Rehabilitation, Inpatient	Yes	Yes	Yes	Yes	Yes	Yes
Admissions	Skilled Nursing Facility	Yes	Yes	Yes	Yes	Yes	Yes
Audiology	Audiological/Audiometric Testing	No	No	No	No	No	Yes
Audiology	Hearing Exam/Hearing Aid Evaluation	No	No	No	No	No	No
Behavioral	Behavioral/emotional assessment, brief (ADHD/depression,etc)	No	No	No	No	No	No
Behavioral	Child Developmental/Behavioral Evaluations & Testing (Non-routine)	Yes	Yes	Yes	Yes	Yes	Yes
Behavioral	Cognitive Function Testing (CPT 96103, 96116, 96120)	Yes	Yes	Yes	Yes	Yes	Yes
Behavioral	Counseling (In Network Mental Health)	No	No	No	No	No	Yes
Behavioral	Drug Abuse	No	No	No	No	No	NOT COVERED
Behavioral	Hypnosis	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Behavioral	Neuropsychological Testing	No	No	No	No	No	Yes
Behavioral	Psychiatric Care (In Network)	No	No	No	No	No	No
Behavioral	Psychological Testing	No	No	No	No	No	No
Behavioral	Psychotherapy	No	No	No	No	No	No
Behavioral	Residential Treatment Center	Yes	Yes	Yes	Yes	Yes	NOT COVERED
Behavioral	Smoking Cessation Counseling	No	No	No	No	No	NOT COVERED
Breast	Ablation, Cryosurgical, of Fibroadenoma	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Breast	Augmentation Mammoplasty	Yes	Yes	Yes	Yes	Yes	Yes
Breast	Breast Biopsy, Excisional	No	No	No	No	No	Yes
Breast	Breast Biopsy, Local/Needle	No	No	No	No	No	No
Breast	Breast Implant Removal	No	No	No	No	No	Yes
Breast	Mammogram (Routine, Diagnostic, Screening, Spot Compression)	No	No	No	No	No	No
Breast	Mammoplasty, Reduction	Yes	Yes	Yes	Yes	Yes	Yes
Breast	Post Mastectomy Prosthesis	No	No	No	No	No	Yes
Breast	Post Mastectomy Reconstructive Breast Surgery	Yes	Yes	Yes	Yes	Yes	Yes
Cardiology	Adenosine/Cardiolyte Stress Test	No	No	No	No	No	Yes
Cardiology	Angiogram	Yes	Yes	Yes	Yes	Yes	Yes
Cardiology	AV Graft/Fistula for Hemodialysis	No	No	No	No	No	Yes
Cardiology	Cardiac Catheterization, Stent, Angioplasty	No	No	No	No	No	Yes
Cardiology	Cardiac Monitor, Insertable (Reveal)	Yes	Yes	Yes	Yes	Yes	Yes
Cardiology	Cardiac Rehabilitation (max 36 sessions)	No	No	No	No	No	No
Cardiology	CardioChek	NOT COVERED	No	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Cardiology	Cardioversion	No	No	No	No	No	No
Cardiology	Defibrillator, External (Zoll Life Vest, 3 months max)	Yes	Yes	Yes	Yes	Yes	NOT COVERED
Cardiology	Event Monitor (Holter Monitor)	No	No	No	No	No	Yes
Cardiology	Pacemaker Telephonic Checks (monthly)	No	No	No	No	No	No
Cardiology	Pacemaker Monitoring (CPT 93279-93298)	No	No	No	No	No	No
Cardiology	TAVR	Yes	Yes	Yes	Yes	Yes	NOT COVERED
Cardiology	Ventricular Assist Device	Yes	Yes	Yes	Yes	Yes	NOT COVERED
Chemotherapy	Chemo FX Assay	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Chemotherapy	Chemotherapy (excludes research protocols)	Yes	Yes	Yes	Yes	Yes	Yes
Chemotherapy	Clinical Trials (See NCI)	Yes	Yes	Yes	Yes	Yes	NOT COVERED
Chemotherapy	NCI Clinical Trials	Yes	Yes	Yes	Yes	Yes	NOT COVERED
Custodial Care	Custodial Care (nursing home is member's home)	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Custodial Care	Long Term Care (Custodial Care)(Nursing Home is member home)	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Dermatolgy	Abrasion Treatment, Dermabrasion, Salabrasion	Yes	Yes	Yes	Yes	Yes	NOT COVERED
Dermatolgy	Chemical Exfoliation for Acne	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Dermatolgy	Electrolysis	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Dermatolgy	Hair Transplant	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Dermatolgy	Laser Treatment for Psoriasis	No	No	No	No	No	NOT COVERED
Dermatolgy	Light/Ultraviolet Therapy	No	No	No	No	No	NOT COVERED
Dermatolgy	Mohs Surgery	No	No	No	No	No	Yes
Dermatolgy	Psoralen & Ultraviolet Light Therapy (PUVA)	No	No	No	No	No	NOT COVERED
Dermatolgy	Scar Revision	Yes	Yes	Yes	Yes	Yes	Yes
Diagnostic Testing	Polysommography (Sleep Study)	Yes	Yes	Yes	Yes	Yes	Yes
Diagnostic Testing	Stress Test- Treadmill test	No	No	No	No	No	No
Diagnostic Testing	Thoracoscopy, Diagnostic	No	No	No	No	No	Yes
Diagnostic Testing	Endoscopy	No	No	No	No	No	Yes
Diagnostic Testing	Bio Wellness Scan (CPT 95921, 95922)	No	No	No	No	No	NOT COVERED
DME	Ambulatory Blood Pressure Monitoring	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
DME	Bath/Shower Chair	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	No
DME	Bed Board	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	No
DME	Bone Growth Stimulator	Yes	Yes	Yes	Yes	Yes	NOT COVERED

DME	Braces (Orthopedic)	No if less than $500	No if less than $500	No if less than $500	No if less than $500	No if less than $500	No, if less than $250
DME	Bra-Post Mastectomy	No	No	No	No	No	Yes
DME	Breast Prosthesis	No	No	No	No	No	Yes
DME	Breast Pump (Manual, Electric)	No	No	No	No	No	Yes
DME	Cane	No	No	No	No	No	No
DME	Cast, Application and Removal	No	No	No	No	No	No
DME	Cochlear Implant	Yes	Yes	Yes	Yes	Yes	NOT COVERED
DME	Colostomy Supplies	No	No	No	No	No	No
DME	Commode, Bedside specifc to 3-n-1	No	No	No	No	No	No
DME	Continuous Glucose Monitoring System (CGMS)	No	No	No	No	No	NOT COVERED
DME	CPAP Machine	No	No	No	No	No	Yes
DME	CPAP Supplies (auto auth, 2 per max)	No	No	No	No	No	Yes
DME	CPM Machine	No	No	No	No	No	Yes
DME	Crutches (1 per year max)	No	No	No	No	No	No
DME	Diabetic Shoes/Custom Orthotics	No	No	No	No	No	Yes
DME	Diabetic Supplies	No	No	No	No	No	No
DME	Diapers	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
DME	Durable Medical Equipment, Convenience/Hygienic/Environmental Control Items	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
DME	Durable Medical Equipment-If not otherwise listed and by contracted price	Yes over $500	Yes over $500	Yes over $500	Yes over $500	Yes over $500	Yes over $250
DME	Electric Wheelchair	Yes	Yes	Yes	Yes	Yes	Yes
DME	Elevator	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
DME	Enteral Nutrition/Enteral Feedings	Yes	Yes	Yes	Yes	Yes	Yes
DME	ERMI Extensionater/Flexionater	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
DME	Foot Board	No	No	No	No	No	NOT COVERED
DME	Glucometer/Test Strips	No	No	No	No	No	No
DME	Grab Bar	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
DME	Hearing Aid	NOT COVERED	Yes	Yes	See Benefits	See Benefits	Yes
DME	Hospital Bed	Yes	Yes	Yes	Yes	Yes	Yes
DME	Humidifier	NOT COVERED	No	No	No	No	No
DME	Hydrotherapy (Pool Therapy)	Yes	Yes	Yes	Yes	Yes	NOT COVERED
DME	Incontinence Pads	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
DME	Insulin Pumps	Yes	Yes	Yes	Yes	Yes	Yes
DME	Nebulizer	No	No	No	No	No	No
DME	Ostomy Supplies	No	No	No	No	No	No
DME	Oxygen Equipment, Portable and Stationary	Yes	Yes	Yes	Yes	Yes	Yes
DME	Patient Lifts	Yes	Yes	Yes	Yes	Yes	Yes
DME	Ramps	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
DME	TENS Unit-Vendor needed	No	No	No	No	No	No
DME	Toilet Seat, Raised	NOT COVERED	NOT COVERED	NOT COVERED	Yes	Yes	No
DME	Traction Equipment	No	No	No	No	No	No
DME	Travel /Transport Chair	No	No	No	No	No	No
DME	Walker, Rolling	No	No	No	No	No	No
DME	Wheelchair Cushion	No	No	No	No	No	No
DME	Wheelchair, Standard	No	No	No	No	No	No
DME	Whirlpool (Portable & Built In)	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
DME	Wig (oncology related, max 1 per year)	No	No	No	No	No	NOT COVERED
ENT	Allergy Injections	No	No	No	No	No	NOT COVERED
ENT	Allergy Testing	No	No	No	No	No	NOT COVERED
ENT	Laryngoscopy	No	No	No	No	No	Yes
Eye	Blepharoplasty	Yes	Yes	Yes	Yes	Yes	Yes
Eye	Cataract Extraction	No	No	No	No	No	Yes
Eye	Eye Examinations-Annual or Routine	No	No	No	No	No	Yes
Eye	Eye Injections	No	No	No	No	No	Yes
Eye	Lasik Surgery	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Eye	Punctum Plug	No	No	No	No	No	Yes
Eye	Retinal Detachment	No	No	No	No	No	No
Eye	Shunts, Glacoma	No	No	No	No	No	Yes
Eye	Vitrectomy	No	No	No	No	No	Yes
Eye	YAG Laser Surgery	No	No	No	No	No	Yes
Family Planning	Artificial Insemination	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Family Planning	Family Planning	MERITAIN	No	No	NOT COVERED	NOT COVERED	NOT COVERED
Family Planning	Infertility & Impotence Services	MERITAIN	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Family Planning	In-Vitro Fertilization	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Family Planning	Surgical Sterilization (female)	MERITAIN	No	No	No	No	NOT COVERED
Family Planning	Vasectomy	MERITAIN	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Female Reproduction	Colposcopy	No	No	No	No	No	Yes
Female Reproduction	Hysterectomy	No	No	No	No	No	Yes (Only Oncology)
Female Reproduction	Hysteroscopy	No	No	No	No	No	Yes
Female Reproduction	Induction of Labor	No	No	No	No	No	No
Female Reproduction	Maternity Services, Pre and Post Natal	No	No	No	No	No	Yes

Female Reproduction	Uterine Artery Embolization (UAE)	Yes	Yes	Yes	Yes	Yes	Yes
Gastroenterology	Anoscopy	No	No	No	No	No	No
Gastroenterology	Bariatric Surgery (Vertical Banding, Lap Band, Gastric Sleeve, bypass etc.)	Yes	NOT COVERED	NOT COVERED	Yes	Yes	NOT COVERED
Gastroenterology	Barium Swallow, Modified	No	No	No	No	No	Yes
Gastroenterology	Colonoscopy	No	No	No	No	No	Yes
Gastroenterology	Endoscopy, Gastrointestinal (EGD)	No	No	No	No	No	Yes
Gastroenterology	Esophageal Motility (Oral Capsule Camera)	Yes	Yes	Yes	Yes	Yes	Yes
Genetic	BRCA 1 & 2	Yes	Yes	Yes	Yes	Yes	Yes
Genetic	Genetic Counseling/Testing	Yes	Yes	Yes	Yes	Yes	NOT COVERED
Genetic	HNPCC Genetic Screening	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Genetic	Oncotype DX	Yes	Yes	Yes	Yes	Yes	Yes
Home Health	Hospice Care	Yes	Yes	Yes	Yes	Yes	Yes
Home Health	Private Duty Nurse	NOT COVERED	NOT COVERED	Yes	NOT COVERED	NOT COVERED	NOT COVERED
Home Health	Respite Care	Yes	NOT COVERED	Yes	Yes	Yes	NOT COVERED
Imaging	Bone Density, DEXA	No	No	No	No	No	No
Imaging	Bronchoscopy	No	No	No	No	No	Yes
Imaging	BSGI (Breast-Specific Gamma Imaging)	NOT COVERED	Yes	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Imaging	Cisternogram	No	No	No	No	No	Yes
Imaging	CT Scans/CT Myelograms/CT Angiogram	No	No	No	No	No	No
Imaging	Discogram	No	No	No	No	No	No
Imaging	Doppler/Duplex Scan	No	No	No	No	No	No
Imaging	Echocardiogram (doppler, transthoracic or transophageal)	No	No	No	No	No	No
Imaging	Electrocardiogram (EKG)	No	No	No	No	No	No
Imaging	Electroencephalogram (EEG)	No	No	No	No	No	No
Imaging	Electromyogram (EMG)	No	No	No	No	No	Yes
Imaging	ERCP	No	No	No	No	No	Yes
Imaging	Gastric Emptying Study	No	No	No	No	No	Yes
Imaging	HIDA-Hepatobiliary ductal system imaging	No	No	No	No	No	Yes
Imaging	MBI (Molecular Breast Imaging)	Yes	Yes	Yes	Yes	Yes	Yes
Imaging	MRA	No	No	No	No	No	Yes
Imaging	MRCP	No	No	No	No	No	Yes
Imaging	MRI, Open MRI Only	Yes	Yes	Yes	Yes	Yes	Yes
Imaging	MUGA (Multiple Gated Acquisition)	No	No	No	No	No	Yes
Imaging	Myocardial Perfusion Imaging (SPECT)	No	No	No	No	No	Yes
Imaging	Nuclear Medicine Studies only including: Nuclear Stress Test, and Thyroid Scans- See List by system: Endocrine System: 78012-78099; Hematopoietic & Lymphatic Sytem: 78102-78199; Gastrointestinal Sustem: 78201-78299; Musculoskeletal System: 78300-78399; Cardiovascular System: 78414-78499; Respriatory System: 78579-78599; Nervous System: 78600-78699; Genitourinary System: 78700-78799; Other: 78800-78999; Therapeutic: 79005-79999	No	No	No	No	No	Yes
Imaging	PAD/PDD (Arterial Studies, CPT 93922)	No	No	No	No	No	No
Imaging	PET Scan	Yes	Yes	Yes	Yes	Yes	Yes
Imaging	Radiology, Office Setting, X-Ray	No	No	No	No	No	No
Imaging	Scintimammography	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Imaging	Ultrasound	No	No	No	No	No	No
Imaging	Whole Body Bone Scan	No	No	No	No	No	Yes
Labatory and Pathology	Biopsy/Local Anesthesia/Office Setting	No	No	No	No	No	No
Labatory and Pathology	Blood Transfusion	No	No	No	No	No	No
Labatory and Pathology	Bone Marrow Aspiration/Biopsy	No	No	No	No	No	Yes
Labatory and Pathology	Laboratory Studies	No	No	No	No	No	No
Labatory and Pathology	Phlebotomy	No	No	No	No	No	No
Medication	Botullinum Toxin A Injection (Botox)	Yes	Yes	Yes	Yes	Yes	Yes
Medication	Drug, 17P	No	No	No	No	No	No
Medication	Drugs, High Cost /Infusion Medication	Yes	Yes	Yes	Yes	Yes	Yes
Medication	Immunizations & Vaccinations for Travel	No	No	No	No	No	NOT COVERED
Medication	Immunizations & Vaccinations, Routine	No	No	No	No	No	No
Medication	VANTAS (Histrelin Implant)	Yes	Yes	Yes	Yes	Yes	Yes
Neurology	Kyphoplasty/Vertebroplasty	Yes	Yes	Yes	Yes	Yes	Yes
Neurology	Lumbar Puncture	No	No	No	No	No	No
Neurology	Total Disc Arthroplasty, Artificial Disc	No	No	No	No	No	Yes
Office	Diabetic Education	No	No	No	No	No	No
Office	Home visit, Physician	No	No	No	No	No	NOT COVERED
Office	Nutritional Counseling (exception diabetic education)	No	No	No	No	No	Yes
Office	Office Visit, PCP	No	No	No	No	No	No
Office	Office Visit, Specialist	No	No	No	No	No	No

Office	Physicals, Annual Routine	No	No	No	No	No	No
Office	Physicals, Annual Sports	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Office	Telemedicine	Yes	Yes	Yes	Yes	Yes	NOT COVERED
Oral	Craniomandibular Joint (CMJ) (does not refer to TMJ)	Yes	Yes	Yes	Yes	Yes	NOT COVERED
Oral	Dental Implants	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Oral	Dental Procedures & Supplies-N/A	Yes	Yes	Yes	Yes	Yes	Yes
Oral	Oral Surgery	Yes	Yes	Yes	Yes	Yes	NOT COVERED
Oral	Orthodontia	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Oral	TMJ Treatment	Yes	Yes	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Orthopedic	Arthroscopy	No	No	No	No	No	Yes
Orthopedic	Hip Replacement	Yes	Yes	Yes	Yes	Yes	Yes
Orthopedic	Knee Replacement	Yes	Yes	Yes	Yes	Yes	Yes
Orthopedic	Trigger Finger	No	No	No	No	No	Yes
Pain Management	Acupuncture (max 35 sessions per year)	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	No	NOT COVERED
Pain Management	Chiropractic Treatment	NOT COVERED	Yes	NOT COVERED	Yes	Yes	Yes
Pain Management	Drug Screening for Pain Management Patients	No	No	No	No	No	No
Pain Management	Epidural Steroid Injection (ESI)	No	No	No	No	No	Yes
Pain Management	Intra articular Injection	No	No	No	No	No	No
Pain Management	Nerve Block	No	No	No	No	No	Yes
Pain Management	Neuromuscular Stimulator (implanted)	Yes	Yes	Yes	Yes	Yes	Yes
Podiatry	Extracorporeal Shock Wave involving Plantar Fascia	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Podiatry	Foot Care Routine(corns,calluses,nail trims,debridement)	No	No	NOT COVERED	No	No	Yes
Podiatry	Foot Care, Non-Routine (injury/trauma)	No	No	No	No	No	No
Podiatry	Podiatry Services	No	No	No	No	No	Yes
Pulmonology	Pulmonary Function/Stress Test	No	No	No	No	No	No
Pulmonology	Pulmonary Rehabilitation (max 36 sessions)	No	No	No	No	No	Yes
Pulmonology	Thoracentesis	No	No	No	No	No	Yes
Radiation	Brachytherapy	Yes	Yes	Yes	Yes	Yes	Yes
Radiation	Radiation Therapy	Yes	Yes	Yes	Yes	Yes	Yes
Renal	Dialysis (Hemodialysis or Peritoneal)	No	No	No	No	No	Yes
Skin	Lymphedema Pump/Therapy	Yes	Yes	Yes	Yes	Yes	Yes
Surgery	I & D Procedures	No	No	No	No	No	No
Surgery	Reconstructive (Plastic) Surgery Ex: Trauma, Oncology	Yes	Yes	Yes	Yes	Yes	Yes
Surgery	Surgeries not otherwise listed	Yes	Yes	Yes	Yes	Yes	Yes
Surgery	Transplants	Yes	Yes	Yes	Yes	Yes	NOT COVERED
Therapy	Diathermy Machine	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Therapy	Biofeedback	No	No	No	No	No	NOT COVERED
Therapy	Chelation Therapy	Yes	Yes	Yes	Yes	Yes	Yes
Therapy	Cold Therapy Devices	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Therapy	Exercise Equipment	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Therapy	Exercise Programs	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Therapy	Home Health Care (SNV, PT, OT, SP, HHA)	Yes	Yes	Yes	Yes	Yes	Yes
Therapy	Massage	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Therapy	Occupational Therapy	Yes	Yes	Yes	Yes	Yes	Yes
Therapy	Occupational Therapy Evaluation	No	No	No	No	No	Yes
Therapy	Physical Therapy	Yes	Yes	Yes	Yes	Yes	Yes
Therapy	Physical Therapy Evaluation, Initital	No	No	No	No	No	Yes
Therapy	Speech Evaluation	No	No	No	No	No	No
Therapy	Speech Therapy	Yes	Yes	Yes	Yes	Yes	Yes
Therapy	VRT (Vestibular Rehab Therapy)	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Travel	Ambulance, Air	Yes	Yes	Yes	Yes	Yes	Yes
Travel	Ambulance, Ground, Emergency	No	No	No	No	No	No
Travel	Ambulance, Ground, Non Emergency - Except tranfers from facility to facility.	Yes	Yes	Yes	Yes	Yes	Yes
Urology	Bladder Aorta Scan	No	No	No	No	No	No
Urology	Bladder Stimulator	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Urology	Circumcision	No	No	No	No	No	NOT COVERED
Urology	Cystometrogram (CMG)	No	No	No	No	No	No
Urology	Cystoscopy	No	No	No	No	No	No
Urology	Cystourethroscopy	No	No	No	No	No	No
Urology	Erectile Dysfunction Treatment (Max 3 per week)	No	NOT COVERED	No	No	No	NOT COVERED
Urology	Proctosigmoidoscopy	No	No	No	No	No	Yes
Urology	Transuretheral Resection of Bladder Tumor (TURBT)	Yes	Yes	Yes	Yes	Yes	Yes
Urology	Urethral Pressure Profile (UPP)	No	No	No	No	No	No
Urology	Urodynamic Studies	No	No	No	No	No	No
Urology	Uroflowmetry (UFR)	No	No	No	No	No	No
Urology	Urostomy Supplies	No	No	No	No	No	No
Urology	Voiding Pressure Study (VP)	No	No	No	No	No	No
Vascular	Port-a-Cath Flush-Office Based	No	No	No	No	No	No
Vascular	Port-a-Cath Flush-Outpt Hospital	No	No	No	No	No	No
Vascular	Port-a-Cath Insertion	No	No	No	No	No	Yes

Vascular	Varicose Vein Treatment	Yes	Yes	Yes	Yes	Yes	Yes
Wound Care	Debridement-Wounds	No	No	No	No	No	No
Wound Care	Hyperbaric (HBO)	Yes	Yes	Yes	Yes	Yes	Yes
Wound Care	Negative Pressure Wound Therapy Pump (KCl)	Yes	Yes	Yes	Yes	Yes	Yes