

Coverage of any medical intervention discussed in a Prevea360 Health Plan medical policy is subject to the limitations and exclusions outlined in the member's benefit certificate or policy and to applicable state and/or federal laws.

Non-covered Medical Procedures and Services

MP9415

Prevea360 Health Plan Medical Policy:

1.0 **Table 1.0** lists **some** procedures and services that are not covered by Prevea360 Health Plan because they: (1) failed to meet the Prevea360 definition of medical necessity; or (2) are considered investigational and/or experimental. The list is **not** all inclusive.

Table 1.0. Non-covered Medical Procedures and Services (Not An All Inclusive List)

Abbreviations: *NMN* = not medically necessary; *E/I* = experimental and/or investigational;

Procedure Description	Indication	Reason Not Covered
Acclarent Aera Eustachian Tube Balloon Dilation System (e.g. XprESS ENT Dilation System) (69705, 69706, 69799) except for chronic eustachian tube dysfunction	All indications other than treatment of chronic eustachian tube dysfunction	E/I
Alopecia Treatment	Without a specific disease related condition	NMN
Autologous chondrocyte transplantation (ACT) (0481T)	Osteochondral defects of all joints except the knee	NMN
Automated point of care nerve conduction studies (95905)	Noninvasive method of diagnosing and evaluating systemic and entrapment neuropathy.	E/I
Axial Lumbar Interbody Fusion (AxiaLIF) (22586)	All indications	E/I
Biodex (Quantitative Muscle Testing device)	All indications	E/I
Bioimpedance Spectroscopy or Bioelectric Impedance Analysis (e.g. SOZO, ImpediMed L-Dex U400) (93702, 0358T)	Detection of lymphedema, measurement of total body water, extracellular and intracellular fluid volumes	E/I
Body Surface-Activation Mapping of Pacemaker or Pacing Cardiodefibrillator (0695T, 0696T)	All indications	E/I
Brava Breast Expander	All indications including breast reconstruction following mastectomy	E/I
Breast CT including 3D Rendering (0633T, 0634T, 0635T, 0636T, 0637T, 0638T))	All indications	E/I
Breast Ductal Lavage for Cytology (19499)	Women at high risk for breast cancer.	NMN
	For women with abnormal nipple discharge or as an intraoperative tool to guide surgery.	NMN
	For women at average risk for breast cancer; abnormal findings on clinical breast examination and/or mammography; or irradiation or surgery on the breast to be lavaged, or those receiving	E/I

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	chemotherapy, tamoxifen, or selective estrogen receptor modulators.	
Breast Thermography	Screening for breast cancer and other breast diseases.	E/I
Carotid Intima Medial Thickness Measurement (CIMT) Ultrasound (93895, 0126T)	All indications	NMN
Closed Loop Insulin Delivery System (e.g. artificial pancreas device system) (S1034, S1035, S1036, S1037))	All indications	E/I
Computed Tomographic Angiography (CTA), coronary atherosclerotic plaque (0623T, 0624T, 0625T, 0626T)	Severity of coronary disease and all other indications	E/I
Computer Based Treatment for Cognitive Behavioral Therapy (CBTCBT) for Substance Use Disorders (e.g. reSET and reSET-O) (A9291)	For treatment of substance use disorders	E/I
Constraint Induced Movement Therapy	All indications other than treatment of upper limb hemiparesis	NMN
Cord blood harvesting for transplantation; allogeneic (S2140, S2142)	Prophylactic collection and storage of umbilical cord blood when proposed for an unspecified future use for an autologous stem cell transplant in the original donor or for an unspecified future use as an allogeneic stem cell transplant in a related or unrelated donor.	NMN
	For patients for whom a well-matched bone marrow donor is available.	NMN
	For patients not meeting patient selection criteria for AIBMT.	E/I
Cord blood storage (88240)	All indications	NMN
Cranial Electrotherapy Stimulation (CES) (e.g. Alpha Stim) (E1399, K1002)	Behavioral disorders including, but not limited to, depression and anxiety	E/I
Craniosacral Therapy (97139)	All indications	E/I
Cryoablation nasal tissue and/or nerves (e.g. Clarifix) (C9771)	Chronic sinusitis and all other indications	E/I
Cryogenic surgical device (e.g. iovera System) (0441T)	Relief of pain and symptoms associated with osteoarthritis of the knee and peripheral nerve pain	E/I

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Dry Hydrotherapy	All indications	NMN
Elastography; parenchyma (e.g. FibroScan) (76981) Magnetic resonance (e.g. vibration) elastography (76391, 91200)	For any chronic liver disease; no other indications covered For chronic liver disease and need to assess for advanced fibrosis or cirrhosis or nonalcoholic fatty liver disease, and distinguishing hepatic cirrhosis from non-cirrhosis known or suspected, no other indications covered	E/I
Electrical impedance spectroscopy of 1 or more skin lesions (0658T) (e.g. Nevisense)	For automated melanoma risk score	E/I
Electrical Stimulation to Treat Chronic Wounds (G0281, G0282, G0295, G0329))	As an adjunct to standard wound care in the treatment of chronic, non-healing dermal ulcers including pressure sores, venous stasis ulcers, arterial ulcers, surgical wounds, and diabetic foot wounds.	NMN
	For the treatment of acute dermal ulcers or cutaneous wounds other than pressure sores, venous stasis ulcers, arterial ulcers, surgical wounds, and diabetic foot wounds.	E/I
Endoscopic laser foraminoplasty	All indications	E/I
Endoscopic implantation of Plexigas (PMMA) microspheres polymethylmethacrylate beads into lower esophageal folds	Gastroesophageal reflux disease	E/I
Epiduroscopy	For the diagnosis and treatment of intractable low back pain or other indications.	E/I
Esophageal mucosal integrity testing by electrical impedance, transoral (e.g. MiVu) (C9777)	GERD or any other indication	E/I
Excimer laser therapy	Atopic Dermatitis, lichen planus	E/I
External upper limb tremor stimulator of the peripheral nerves of the wrist (K1018) (Cala Trio)	For the treatment of essential tremor	E/I
EyeBOX System (Adjunctive Oculomotor Assessment Aid) (0615T)	For traumatic brain injury, concussion, or all other indications	E/I
Foot adductus positioning device (e.g. UNFO-S) (K1015)	For the treatment of metatarsus adductus	E/I
Ganglion Impairment Block	All indications	E/I
Glomerular Filtration Rate (GFR), Transdermal (0602T, 0603T)	All indications	E/I

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Hand Rehabilitation System (H200 Wireless, Bioness) Functional E Stim (E0770)	All indications	E/I
Herpes Zoster (Shingles) Vaccine	SHINGRIX vaccine for members who are 49 years of age or younger. Covered if criteria MP9549 Shingrix, Non-Routine is met ZOSTAVAX vaccine for members who are 59 years of age and younger	NMN
Hydrodissection therapy	Pain treatment	E/I
Hyperhomocysteinemia-MTHFR Gene mutation testing (81291)	All indications	NMN
Intense physical therapy suit (Suit Therapy)	All indications	E/I
Interferential current stimulation (e.g. Sanexa, neo-Gen Series, Dynatron Sympathetic Current Therapy Device) (S8130, S8131, E1399)	All indications	E/I
Interleukin-6 (IL-6) (83529)	All indications	E/I
Interspinous Distraction Devices (includes XStop, Coflex, DIAM, Wallis) (C1821)	All indications	E/I
Intradiscal biaculoplasty	For the treatment of lumbar discogenic pain or other indications.	E/I
Intradiscal electrothermal annuloplasty (IEA) (e.g. SpineCATH, Oratec Interventions System)(22526, 22527)	All indications	E/I
Intradiscal electrothermal therapy (IDET) (22526, 22527)	For relief of discogenic pain or other indications.	E/I
Insulin delivery system (V-GO) (A9274)	For the management of Diabetes	E/I
Intra-atrial recording (e.g. AtriAmp) (93602)	All indications	E/I
Intravascular Lithotripsy (e.g. Shockwave Medical Peripheral IVL System) (C9772, C9773, C9774, C9775)	Lithotripsy enhanced balloon dilatation of peripheral arteries	E/I
Intravertebral body fracture augmentation with implantable DME (e.g. KIVA, Vertebral Body Stent, V-Strut) (C1062)	All indications	E/I

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Iontophoresis	For indications other than hyperhidrosis when meets specified criteria	NMN
Iris Prosthesis (e.g. CUSTOMFLEX ARTIFICIAL/IRIS) (0616T 0617T 0618T C1839)	All indications	E/I
Irreversible Electroporation (e.g. NanoKnife System) (0600T, 0601T)	All indications	E/I
Kinematic and Kinetic Motion Analysis Markless 3D (e.g. DARI Motion) (0693T)	All indications	E/I
Laser Interstitial Thermal Therapy (LITT) Intracranial (61736, 61737)	All indications	E/I
Low-Pressure Pulse Generator (e.g. Menniect) (E2120)	For treatment of Meniere's Disease	E/I
Lymphovenous Bypass Surgery (38308)	All indications	E/I
Macular degeneration home monitoring (e.g. ForseeHome AMD) (0378T, 0379T)	All indications	E/I
Magnetic Capsule Endoscopy (e.g. NaviCam) (0651T)	All indications	E/I
Magnetic Resonance Guided Focused Ultrasound Therapy (0071T, 0072T)	Symptomatic uterine fibroids	NMN
Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRgFUS) and High Intensity Focused Ultrasound (HIFU) (e.g. Sonablate 450, Ablatherm) (0071T, 0072T, 55880, 55899, 0398T, C9734)	Covered for Medicare members with essential tremor meeting LCD criteria. Non-covered for all other lines of business MedicareMRgFUScriteria	E/I
Magnetic Resonance Neurography	All indications	E/I
Micro Debridement (Topaz)	All indications	E/I
Migraine Headache Surgery	Migraine Headache	E/I
Minimally invasive facet fusion with allograft. (e.g. TruFuse, Fusio, NuFix) (0219T, 0220T, 0221T, 0222T)	All indications	E/I
Molecular Breast Imaging Technetium-99m Sestamibi Scintigraphy (A9500, S8080)	Breast cancer screening and diagnosis	E/I
MRI guided high intensity focused ultrasound ablation (0071T, 0072T)	For the treatment of uterine fibroids.	NMN

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Nasal valve collapse repair subcutaneous/submucosal lateral wall implants (e.g. Latera absorbable nasal implant) (30468, 30999, C9749)	For treatment of nasal valve collapse and all indications	E/I
Neurofeedback or biofeedback (with or without EEG guidance) (90875, 90876)	For any behavioral or substance abuse disorder	E/I
Neutron beam radiotherapy	All indications other than treatment of salivary gland tumors	E/I
Neuromonics tinnitus treatment	Tinnitus retraining therapy	NMN
Neuromuscular electrical stimulation	All indications except for diaphragm stimulation (ALS patients) and disuse atrophy.	NMN
Neurostimulator generator (implantable), with carotid sinus baroreceptor stimulation lead (e.g. BaroStim Therapy) (C1825, 0266T, 0267T, 0268T, 0269T, 0270T, 0271T, 0272T, 0273T))	Heart failure and all other indications	E/I
Percutaneous arteriovenous fistula creation (AVF) by tissue approximation using thermal resistance energy (G2170) (e.g. Ellipsys) and using magnetic-guided arterial and venous catheters and radiofrequency energy (G2171) (e.g. Wavelin Q)	All indications	E/I
Percutaneous injection of allogenic cellular and/or tissue-based product, intervertebral disc, lumbar (0627T, 0628T, 0629T, 0630T)	All indications	E/I
Percutaneous intradiscal radiofrequency thermocoagulation (PIRFT), also known as percutaneous radiofrequency thermomodulation, Coblation percutaneous disk decompression or Nucleoplasty.(22526, 22527)	All indications	E/I
Percutaneous ultrasound ablation of soft tissue (TX1 Tissue Removal System and Tenex Health TX System) (23405, 23406, 24357, 27000, 27005, 27006, 27306, 27602)	All indications	E/I
Peripheral Nerve Stimulator (StimWave)	All indications	NMN

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Preterm Labor Predictive-Risk Stratification (e.g. PreTRM) (0247U)	Spontaneous preterm birth	E/I
Piriformis muscle injection	All indications	E/I
Platelet Rich Plasma/Platelet Rich Fibrin Matrix (0232T)	For acute surgical wounds or chronic cutaneous wounds that have failed standard therapy.	E/I
	For all other indications.	E/I
Prolotherapy (20999, M0076)	All indications	NMN
Propel sinus stents (S1091)	All indications	E/I
Pulmonary Artery Pressure Sensor (Implanted) (CardioMems) (33289, C2624)	All indications	E/I
Pulsed dye laser	Treatment of pseudofolliculitis	NMN
Pulsed Electrical Stimulation (PES)	Treatment of Osteoarthritis (OA)	E/I
Quantitative magnetic resonance for the analysis of tissue composition (e.g. LiverMultiscan) (0648T, 0649T)	For the diagnosis of liver fibrosis and steatosis related to NAFLD and NASH, and all other indications	E/I
Quantitative sensory testing (0106T, 0107T, 0108T, 0109T, 0110T, G0255)	Diagnosis of neuropathy	E/I
Racz procedure (epidural adhesiolysis with the Racz catheter) (62263, 62264)	For the treatment of epidural adhesions, adhesive arachnoiditis, failed back syndrome from multiple previous surgeries for herniated lumbar disk, or other indications.	E/I
Radiofrequency lesioning of dorsal root ganglia	Back pain	E/I
Sacroplasty (0200T, 0201T)	For osteoporotic sacral insufficiency fractures and other indications	E/I
Signal Averaged Electrocardiography (SAECG) (93278)	All indications	E/I
Sinus Tarsi Implant (e.g. subtalar implant) (0335T, 0510T, 0511T, S2117)	All indications	E/I
Sphenopalatine ganglion (SPG) block using intranasal technology (e.g. Tx360 nasal applicator)	All indications, including chronic migraine	E/I
Stereotactic Cingulotomy	For Obsessive Compulsive Disorder (OCD)	E/I
Stuttering treatment devices	Stuttering	E/I
Subchondroplasty Procedure – Injection of bone substitute material	All indications	E/I

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into subchondral defect (0707T)		
Submaximal Stress Testing	Testing to measure cardiorespiratory fitness	NMN
Sympathetic therapy (e.g. Dynatron STS)	All indications	E/I
Therapeutic Ultrafiltration (e.g. Aquadex SmartFlow System) (0692T)	All indications	E/I
Thermal anisotropy measurement and assessment of flow wireless skin sensor (e.g. Flowsense) (0639T)	Measurement/assessment of flown CSF shunt and all other indications	E/I
Thermal pulsation for chronic dry eye and meibomian gland dysfunction; (e.g. iLux Thermal Pulsation System, LipiFlow Thermal Pulsation System) (0207T, 0563T, 67999)	For chronic dry eye and meibomian gland dysfunction and all other indications	E/I
Thermosensor ShuntCheck	Assess shunt function	E/I
Tinnitus retraining therapy	Behavioral training to deal with tinnitus	E/I
Transcatheter Intracardiac Shunt (TIS) creation by sent placement (33745, 33746)	Congenital cardiac anomalies and all other indications	E/I
Transcatheter intracoronary infusion of supersaturated oxygen (e.g. TherOx DownStream System) (0659T)	In conjunction with percutaneous therapy revascularization for acute myocardial infarction and other indications	E/I
Transcutaneous Electrical Modulation Pain Reprocessing (Scrambler Therapy) (0278T)	All indications, including chronic neuropathic pain	E/I
Transcutaneous electric nerve stimulator for functional abdominal pain relief (e.g. IB-Stim) (K1023)	Abdominal pain and all other indications	E/I
Transcutaneous visible light hyperspectral imaging measurement, extremity(e.g. TransQ) (0631T)	Measurement of oxyhemoglobin, deoxyhemoglobin, and tissue oxygenation per extremity and all other indications	E/I
Transesophageal endoscopic gastroplasty (e.g. EsophyX)	Gastroesophageal reflux disease	E/I
Transesophageal radiofrequency to create submucosal thermal lesion (Stretta procedure)	Gastroesophageal reflux disease with A. chronic heartburn or regurgitation B. severe esophagitis or large hiatal hernias	E/I
Trigeminal nerve stimulation system - external non-implantable (e.g. Monarch eTNS) (K1016)	Treatment of attention deficit hyperactivity disorder	E/I
T-Wave Alternans (93025)	All indications	E/I

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Uterine transplantation – donor hysterectomy (0664T, 0665T, 0666T, 0667T, 0668T, 0669T, 0670T)	For treatment of uterine factor infertility and other indications	E/I
Vertebral body tethering (e.g. The Tether) (0655T, 0656T)	For the treatment of pediatric and adolescent idiopathic scoliosis	E/I
Viscosupplementation Therapy	TMJ, including all joints except knee	E/I
Vision Therapy/Orthoptic Therapy	All indications other than convergence disorder	E/I
Vestibular autorotation, Ocular Vestibular Evoked Myogenic Potential (oVEMP), Cervical Vestibular Evoked Myogenic Potential (cVEMP) or Unilateral Centrifugation Test	Vestibular disorders, vestibular migraine, dizziness or any other indication	E/I
Voiding Prosthesis (e.g. inFlow Intraurethral Valve) (0596T, 0597T)	Impaired detrusor contractility or any other indication	E/I
Yeung Endoscopic Spinal Surgery System (Y.E.S.S.)-also known as arthroscopic micro discectomy or percutaneous endoscopic discectomy with or without laser (PELD) (62287, S2348)	All indications	E/I

2.0 Medically Necessary Definition - The Prevea360 Health Insurance benefit certificate defines medical necessary care as those treatment, services or supplies provided by a hospital or health care provider that are required to identify or treat a member's illness or injury and which, as determined by our Health Services Division, are:

2.1 Consistent with the Member's illness or injury; and

2.2 In accordance with generally accepted standards of medical practice; and

2.2.1 "Generally accepted standards of medical practice" means standards that are based on moderate or high quality scientific evidence published in peer-reviewed medical literature.

2.2.2 Moderate or high quality scientific evidence consists primarily of comparison or placebo-controlled clinical trials that directly demonstrate the benefit of the intervention on patient-oriented health outcomes. Nonvalidated surrogate or disease end point controlled or uncontrolled trials, observational trials, partially controlled observational studies and uncontrolled clinical series may be suggestive, but do not by themselves establish sufficient strength of evidence to prove medical necessity.

2.3 Not solely for the convenience of a member, hospital, or other provider; and

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- 2.4 The most appropriate supply or level of service that can be safely provided to the member in the most cost effective manner.
- 3.0 Psychological reactions to appearance or fear of disease do not constitute a basis for medical/surgical necessity, other than for behavioral health services. Services or plastic surgery are not a benefit unless they represent a functional medical necessity.
- 4.0 The fact that a physician has performed or prescribed a procedure or treatment does **not** mean that it is medically necessary.
- 5.0 **Experimental and/or Investigational** - According to the Prevea360 benefit certificate, these are surgical procedures or medical procedures/treatments, supplies or devices, or drugs which at the time provided or sought to be provided, are in the judgment of the Prevea360 Health Plan, Inc. Medical Directors not currently recognized as accepted medical practice and/or the procedure, treatment, supply, device or drug includes, but is not limited to, one of the following:
- 5.1 Has not been approved by the appropriate governmental agency, such as, but not limited to, the U.S. Food and Drug Administration for the purpose it is being used for, which includes the patient's medical condition Is not demonstrated to be as beneficial as established alternatives.
- 5.2 Failure to demonstrate the procedure, treatment, supply, device or drug is safe and effective for the patient's medical condition.
- 5.3 Based on a review of the current peer reviewed medical literature in the United States, there is a failure to demonstrate, at a minimum, an equivalent clinical outcome when compared to standard/conventional treatment for the condition.
- 5.4 Requires a written investigational or research protocol. Is a treatment protocol based upon or similar to those used in on-going clinical trials.
- 5.5 Note: A procedure, treatment, supply, device or drug may be considered experimental or investigational even if the provider has performed, prescribed, recommended, ordered, or approved it, or if it is the only available procedure or treatment for the condition.

CPT/HCPCS Codes Related to MP9415

The list of codes (and their descriptors, if any) is provided for informational purposes only and may not be all inclusive or current. Listing of a code in this medical policy does not imply that the service described by the code is a covered or non-covered service. Benefit coverage for any service is determined by the member's policy of health coverage with Prevea360 Health Plan. Inclusion of a code above does not imply any right to reimbursement or guarantee claim payment. Other medical policies may also apply.

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Document	Committee/Source	Date(s)
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	Medical Director Committee/Medical Affairs	January 16, 2013
	Medical Director Committee/Medical Affairs	February 20, 2013
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	Medical Director Committee/Medical Affairs	February 19, 2014
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	Medical Director Committee/Medical Affairs	November 19, 2014
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	Medical Policy Committee/Quality and Care Management Division	September 21, 2016
	Medical Policy Committee/Quality and Care Management Division	October 31, 2016
	Medical Policy Committee/Quality and Care Management Division	November 16, 2016
	Medical Policy Committee/Quality and Care Management Division	February 15, 2017
	Medical Policy Committee/Quality and Care Management Division	March 15, 2017
	Medical Policy Committee/Quality and Care Management Division	April 19, 2017
	Medical Policy Committee/Quality and Care Management Division	June 21, 2017
	Medical Policy Committee/Quality and Care Management Division	July 19, 2017
	Medical Policy Committee/Quality and Care Management Division	August 16, 2017

Coverage of any medical intervention discussed in a Prevea360 Health Plan medical policy is subject to the limitations and exclusions outlined in the member's benefit certificate or policy and to applicable state and/or federal laws.

Reviewed:	Committee/Source	Date(s)
	Medical Policy Committee/Quality and Care Management Division	September 20, 2017
	Medical Policy Committee/Quality and Care Management Division	October 18, 2017
	Medical Policy Committee/Quality and Care Management Division	December 20, 2017
	Medical Policy Committee/Quality and Care Management Division	January 17, 2018
	Medical Policy Committee/Quality and Care Management Division	February 21, 2018
	Medical Policy Committee/Quality and Care Management Division	March 21, 2018
	Medical Policy Committee/Quality and Care Management Division	April 18, 2018
	Medical Policy Committee/Quality and Care Management Division	May 16, 2018
	Medical Policy Committee/Quality and Care Management Division	June 20, 2018
	Medical Policy Committee/Quality and Care Management Division	July 18, 2018
	Medical Policy Committee/Health Services Division	September 19, 2018
	Medical Policy Committee/Health Services Division	October 17, 2018
	Medical Policy Committee/Health Services Division	December 19, 2018
	Medical Policy Committee/Health Services Division	January 16, 2019
	Medical Policy Committee/Health Services Division	February 20, 2019
	Medical Policy Committee/Health Services Division	March 20, 2019
	Medical Policy Committee/Health Services Division	April 17, 2019
	Medical Policy Committee/Health Services Division	June 19, 2019
	Medical Policy Committee/Health Services Division	July 17, 2019
	Medical Policy Committee/Health Services Division	August 21, 2019
	Medical Policy Committee/Health Services Division	September 19, 2019
	Medical Policy Committee/Health Services Division	October 16, 2019
	Medical Policy Committee/Health Services Division	November 20, 2019
	Medical Policy Committee/Health Services Division	February 19, 2020
	Medical Policy Committee/Health Services Division	April 15, 2020
	Medical Policy Committee/Health Services Division	June 17, 2020
	Medical Policy Committee/Health Services Division	July 15, 2020
	Medical Policy Committee/Health Services Division	August 19, 2020
	Medical Policy Committee/Health Services Division	September 16, 2020
	Medical Policy Committee/Health Services Division	November 18, 2020
	Medical Policy Committee/Health Services Division	January 20, 2021
	Medical Policy Committee/Health Services Division	February 17, 2021
	Medical Policy Committee/Health Services Division	April 21, 2021
	Medical Policy Committee/Health Services Division	May 19, 2021

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	Committee/Source	Date(s)
Reviewed:	Medical Policy Committee/Health Services Division	June 16, 2021
	Medical Policy Committee/Health Services Division	July 21, 2021
	Medical Policy Committee/Health Services Division	August 18, 2021
	Medical Policy Committee/Health Services Division	October 20, 2021
	Medical Policy Committee/Health Services Division	November 17, 2021
	Medical Policy Committee/Health Services Division	January 19, 2022
	Medical Policy Committee/Health Services Division	February 16, 2022
	Medical Policy Committee/Health Services Division	March 16, 2022
	Medical Policy Committee/Health Services Division	May 18, 2022
	Medical Policy Committee/Health Services Division	June 15, 2022

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