

## Code information for Prior Authorization for SmartHealth Members

Due to the sheer volume of information contained in this document and because codes are grouped by category, **please use the search function (CTRL F)** to locate the code or word you are looking for. Services may be listed more than once and have different instructions on obtaining authorization. Please review carefully all items matched in your search.

All inpatient confinements require authorization even if the procedure is not on this list.

Emergency and Observation visits *do not* require authorization. However if those visits result in being admitted to the hospital, the hospitalization will require Authorization.

All Genetic Testing (Except 81519, 81521, 81420) requires Prior Authorization and will not be reviewed retroactively. If you do not see the Genetic Test on list (other than the three mentioned above), it is likely not covered.

Physical/Occupational/Speech Therapy (PT/OT/ST) is limited to 60 visits per calendar year, combined. Over 60 visits requires authorization. Please note on request that 60 visits have been exhausted. Be advised: Codes for these services are not on the PA list as the first 60 visits don't require authorization.

All Cell and Gene Therapy requires Prior Authorization. All must be FDA approved or it is not covered.

All Proprietary Laboratory Analysis Codes are considered Experimental/Investigational unless it is listed on the prior authorization list.

Some items on this list have been retired and do not currently require authorization. Please read all notes carefully for each item.

| CPT, HCPCS<br>or Revenue<br>Code   | Inpatient Revenue Code Description                                     | Comments/ Limitations |
|--|--|-----------------------|
| Please note any elective procedure done as an inpatient also requires prior authorization even if the code is not listed here. |  |                       |
| All Cell/Gene Therapy requires prior authorization.  |  |                       |
| 0100   | All-inclusive room and board plus ancillary - POS 21                   |                       |
| 0101   | All-inclusive room and board - POS 21                                  |                       |
| 0110   | Room and Board Private (one bed) - General - POS 21                    |                       |
| 0111   | Room and Board Private (one bed) - Medical/Surgical/GYN - POS 21       |                       |
| 0112   | Room and Board Private (one bed) - OB - POS 21                         |                       |
| 0113   | Room and Board Private (one bed) - Pediatric - POS 21                  |                       |
| 0114   | Room and Board Private (one bed) - Psychiatric - POS 21                |                       |
| 0115   | Room and Board Private (one bed) - Hospice - POS 21                    |                       |
| 0116   | Room and Board Private (one bed) - Detoxification - POS 21             |                       |
| 0117   | Room and Board Private (one bed) - Oncology - POS 21                   |                       |
| 0118   | Room and Board Private (one bed) - Rehab - POS 21                      |                       |
| 0119   | Room and Board Private (one bed) - Other - POS 21                      |                       |
| 0120   | Long term acute care   |                       |
| 0121   | Room and Board Semi Private (two beds) - Medical/Surgical/GYN - POS 21 |                       |
| 0122   | Room and Board Semi Private (two beds) - OB - POS 21                   |                       |
| 0123   | Room and Board Semi Private (two beds) - Pediatric - POS 21            |                       |
| 0124   | Room and Board Semi Private (two beds) - Psychiatric - POS 21          |                       |
| 0125   | Room and Board Semi Private (two beds) - Hospice - POS 21              |                       |
| 0126   | Room and Board Semi Private (two beds) - Detoxification - POS 21       |                       |
| 0127   | Room and Board Semi Private (two beds) - Oncology - POS 21             |                       |
| 0128   | Level 1 Rehab  |                       |
| 0129   | Level 2 Rehab - acute complex  |                       |
| 0130   | Room & Board - Three and Four Beds General Classification - POS 21     |                       |
| 0131   | Room & Board - Three and Four Beds Medical/Surgical/Gyn - POS 21       |                       |
| 0132   | Room & Board - Three and Four Beds Obstetrics (OB) - POS 21            |                       |
| 0133   | Room & Board - Three and Four Beds Pediatric - POS 21                  |                       |
| 0134   | Room & Board - Three and Four Beds Psychiatric - POS 21                |                       |
| 0135   | Room & Board - Three and Four Beds Hospice - POS 21                    |                       |
| 0136   | Room & Board - Three and Four Beds Detoxification - POS 21             |                       |
| 0137   | Room & Board - Three and Four Beds Oncology - POS 21                   |                       |
| 0138   | Room & Board - Three and Four Beds Rehabilitation - POS 21             |                       |
| 0139   | Room & Board - Three and Four Beds Other - POS 21                      |                       |
| 0140   | Room & Board - Deluxe Private General Classification - POS 21          |                       |
| 0141   | Room & Board - Deluxe Private Medical/Surgical/Gyn - POS 21            |                       |
| 0142   | Room & Board - Deluxe Private Obstetrics (OB) - POS 21                 |                       |
| 0143   | Room & Board - Deluxe Private Pediatric - POS 21                       |                       |
| 0144   | Room & Board - Deluxe Private Psychiatric - POS 21                     |                       |
| 0145   | Room & Board - Deluxe Private Hospice - POS 21                         |                       |
| 0146   | Room & Board - Deluxe Private Detoxification - POS 21                  |                       |
| 0147   | Room & Board - Deluxe Private Oncology - POS 21                        |                       |

| CPT, HCPCS or Revenue Code   | Inpatient Revenue Code Description  | Comments/ Limitations            |
|--|---|----------------------------------|
| Please note any elective procedure done as an inpatient also requires prior authorization even if the code is not listed here. |   |                                  |
| All Cell/Gene Therapy requires prior authorization.  |   |                                  |
| 0148   | Room & Board - Deluxe Private Rehabilitation - POS 21   |                                  |
| 0149   | Room & Board - Deluxe Private Other - POS 21  |                                  |
| 0150   | Room & Board - Ward General Classification - POS 21   |                                  |
| 0151   | Room & Board - Ward Medical/Surgical/Gyn - POS 21   |                                  |
| 0152   | Room & Board - Ward Obstetrics (OB) - POS 21  |                                  |
| 0153   | Room & Board - Ward Pediatric - POS 21  |                                  |
| 0154   | Room & Board - Ward Psychiatric - POS 21  |                                  |
| 0155   | Room & Board - Ward Hospice - POS 21  |                                  |
| 0156   | Room & Board - Ward Detoxification - POS 21   |                                  |
| 0157   | Room & Board - Ward Oncology - POS 21   |                                  |
| 0158   | Room & Board - Ward Rehabilitation - POS 21   |                                  |
| 0159   | Room & Board - Ward Other - POS 21  |                                  |
| 0160   | Room & Board - Other General Classification - POS 21  |                                  |
| 0161   | Hospital at home  | Effective 8/1/2024               |
| 0164   | Other Room & Board - Sterile Environment - POS 21   |                                  |
| 0167   | Room & Board - Other Self Care - POS 21   |                                  |
| 0169   | Room & Board - Other Other - POS 21   |                                  |
| 0170   | Nursery General Classification - POS 21   |                                  |
| 0171   | Nursery Newborn - Level I - POS 21  |                                  |
| 0172   | Nursery Newborn - Level II - POS 21   |                                  |
| 0173   | Nursery Newborn - Level III - POS 21  |                                  |
| 0174   | Nursery Newborn - Level IV - POS 21   |                                  |
| 0179   | Nursery Other - POS 21  |                                  |
| 0190   | General classification - SNF  |                                  |
| 0191   | Subacute Care - Level I - SNF   |                                  |
| 0192   | Subacute Care - Level II - SNF  |                                  |
| 0193   | Subacute Care - Level III - SNF   |                                  |
| 0194   | Subacute Care - Level IV - SNF  |                                  |
| 0199   | Other Subacute Care - SNF   |                                  |
| 0362   | Transplant- small intestine; small intestine/liver; liver; multivisceral; lung/heart/lung; heart; |                                  |
| 0367   | Transplant – kidney   |                                  |
| 0413   | Hyperbaric Oxygen Therapy outpatient revenue code   |                                  |
| 0540   | Ambulance – General   | No auth required If service will |
| 0542   | Ambulance – Medical Transport   | No auth required If service will |
| 0543   | Ambulance – Heart Mobile  | No auth required If service will |
| 0546   | Ambulance – Neonatal  | No auth required If service will |
| 0549   | Ambulance – Other   | No auth required If service will |
| 1000   | General Behavioral Health Accommodations  |                                  |
| 1001   | Residential treatment - psychiatric   |                                  |

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|--|---|-----------------------|
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| All Cell/Gene Therapy requires prior authorization.  |   |                       |
| 1002   | Residential treatment - chemical dependency |                       |

| CPT, HCPCS<br>or Revenue<br>Code  | HCPCS (not contained in other categories) Description   | Comments/ Limitations  |
|---|---|--|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</p> |   |  |
| <p>** S2066,<br/>S2067, S2068<br/>**</p>  | <p>These are non-covered codes. Please use the proper procedure codes instead: 19361, 19364, 19366, 19367, 19368, 19369</p>   | <p>Effective 1/1/2020</p>  |
| <p>A0426</p>  | <p>Ambulance, advanced life support, non emergency transport</p>  | <p>No auth required If service will be billed with 2nd position modifier of D, H, I, N, or S</p> |
| <p>A0428</p>  | <p>Ambulance, basic life support, non emergency transport</p>   | <p>No auth required If service will be billed with 2nd position modifier of D, H, I, N, or S</p> |
| <p>A0430</p>  | <p>Ambulance service, conventional air services, transport, one way (fixed wing)</p>  |  |
| <p>A0431</p>  | <p>Ambulance service, conventional air services, transport, one way (rotary wing)</p>   |  |
| <p>A0432</p>  | <p>Paramedic intercept (PI)0632 rural area, transport furnished by volunteer ambulance company which is prohibited by state law from billing third party payers</p> |  |
| <p>A0434</p>  | <p>Specialty Care Transport (SCT)</p>   | <p>No auth required If service will be billed with 2nd position modifier of D, H, I, N, or S</p> |
| <p>A0435</p>  | <p>Fixed wing air mileage</p>   |  |
| <p>A0436</p>  | <p>Rotary wing air mileage</p>  |  |

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|---|--|---|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</p> |  |   |
| A0999   | Unlisted ambulance service   | No auth required If service will be billed with 2nd position modifier of D, H, I, N, or S |
| A9599   | Radiopharmaceutical, diagnostic for beta-amyloid PET imaging   |   |
| C1607   | Neurostimulator, integrated (implantable), rechargeable with all implantable and external components including charging system | Effective 5/1/2026  |
| C1608   | Prosthesis, total, dual mobility, first carpometacarpal joint (implantable)  | Effective 5/1/2026  |
| C1832   | Autograft suspension, including cell processing and application, and all system components                                     | Effective 9/1/2022  |
| C7566   | Arthrodesis, interphalangeal joints, with or without internal fixation, with autografts (includes obtaining grafts)            | Effective 5/1/2026  |
| C9352   | Microporous collagen implantable tube (NeuraGen Nerve Guide) per cm length   | Effective 1/1/2022  |
| C9353   | Microporous collagen implantable slit tube (Neurawrap Nerve Protector), per cm length  | Effective 1/1/2022  |
| C9354   | Acellular pericardial tissue matrix of nonhuman origin (Veritas), per sq cm  | Effective 1/1/2022  |

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|---|--|--|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</p> |  |  |
| C9355   | Collagen nerve cuff (NeuroMatrix), per 0.5cm length  | Effective 1/1/2022   |
| C9356   | Tendon, porous matrix of cross-linked collagen and glycosaminoglycan matrix (TenoGlide Tendon Protector Sheet)   | Effective 1/1/2022   |
| C9361   | Collagen matrix nerve wrap (Neuromend Collagen Nerve Wrap), per 0.5cm length   | Effective 1/1/2022   |
| C9362   | Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Strip), per 0.5cc  | Effective 1/1/2022   |
| C9363   | Integra meshed bil wound mat   | Effective 1/1/2022   |
| C9364   | Porcine implant, Permacol, per sq cm   | Effective 1/1/2022   |
| C9781   | Arthroscopy, shoulder, surgical; with implantation of subacromial spacer (e.g., balloon), includes debridement (e.g., limited or extensive), subacromial decompression, acromioplasty, and biceps tenodesis when performed | Effective 9/1/2022   |
| C9785   | Endoscopic outlet reduction, gastric pouch application, with endoscopy and intraluminal tube insertion, if performed, including all system and tissue anchoring components   | Effective 10/1/2023  |
| D9223   | General Anesthesia in 15 minute increments   | Pre-certification of Anesthesia is only applicable when dental services are performed in a |

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|---|--|-----------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</p> |  |                       |
| G0277   | Hyperbaric Oxygen Therapy  |                       |
| G0330   | Facility services for dental rehabilitation procedure(s) performed on a patient who requires monitored anesthesia (e.g., general, intravenous sedation (monitored anesthesia care) and use of an operating room    | Effective 1/1/2023    |
| G2020   | Services For High Intensity Clinical Services Associated With The Initial Engagement And Outreach Of Beneficiaries Assigned To The Sip Component Of The Pcf Model (Do Not Bill With Chronic Care Management Codes) | Effective 6/1/21      |
| G2172   | All Inclusive Payment For Services Related To Highly Coordinated And Integrated Opioid Use Disorder (Oud) Treatment Services Furnished For The Demonstration Project   | Effective 6/1/21      |
| H0017   | Behavioral health; residential   | Effective 10/1/25     |
| H0018   | Behavioral health; short-term residential  | Effective 10/1/25     |
| H0019   | Behavioral health; long-term residential   | Effective 10/1/25     |
| S9960   | Ambulance service, conventional air services, non emergency transport, one way (fixed wing)  |                       |
| V2790   | Amniotic membrane for surgical reconstruction per procedure  |                       |

| CPT, HCPCS<br>or Revenue<br>Code   | Skin Substitutes Description                          | Comments/ Limitations |
|--|---|-----------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. When requesting authorization for a skin grafting procedure, the material must be authorized or it may not be covered.</p> |   |                       |
| A2002  | Mirragen advanced wound matrix, per square centimeter | Effective 9/1/2022    |
| A2003  | Bio-connekt wound matrix, per square centimeter       | Effective 9/1/2022    |
| A2006  | Novosorb synpath dermal matrix, per square centimeter | Effective 9/1/2022    |
| A2007  | Restrata, per square centimeter                       | Effective 9/1/2022    |
| A2008  | Theragenesis, per square centimeter                   | Effective 9/1/2022    |

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| A2009   | Symphony, per square centimeter        | Effective 9/1/2022    |
| A2010   | Apis, per square centimeter            | Effective 9/1/2022    |
| A2011   | Supra sdrm, per square centimeter      | Effective 9/1/2022    |
| A2012   | Suprathel, per square centimeter       | Effective 9/1/2022    |
| A2013   | Innovamatrix fs, per square centimeter | Effective 9/1/2022    |

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|---|--|-----------------------|
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| A2014   | Omeza collagen matrix or omeza complete matrix, per 100 mg | Effective 10/1/2022   |
| A2015   | Phoenix wound matrix, per square centimeter                | Effective 10/1/2022   |
| A2016   | Permeaderm b, per square centimeter                        | Effective 10/1/2022   |
| A2017   | Permeaderm glove, each                                     | Effective 10/1/2022   |
| A2018   | Permeaderm c, per square centimeter                        | Effective 10/1/2022   |

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|--|--|---|
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| A2019  | Kerecis Omega3 MariGen Shield, per sq cm           | Effective 10/1/2023                     |
| A2026  | Restrata minimatrix, 5 mg                          | Effective 4/1/24 (added on 5/1/24 list) |
| A2027  | Matriderm, per square centimeter                   | Effective 10/1/24                       |
| A2028  | Micromatrix flex, per mg                           | Effective 10/1/24                       |
| A2029  | Mirotract wound matrix sheet, per cubic centimeter | Effective 10/1/24                       |

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|--|---|-----------------------|
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| A2030  | Miro3d fibers, per milligram                        | Effective 4/1/25      |
| A2031  | Mirodry wound matrix, per square centimeter         | Effective 4/1/25      |
| A2032  | Myriad matrix, per square centimeter                | Effective 4/1/25      |
| A2034  | Foundation drs solo, per square centimeter          | Effective 4/1/25      |
| A2035  | Corplex p or theracor p or allacor p, per milligram | Effective 4/1/25      |

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|---|--|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. When requesting authorization for a skin grafting procedure, the material must be authorized or it may not be covered. |  |                       |
| A4100   | Skin substitute  | Effective 9/1/2022    |
| A9599   | Radiopharmaceutical, diagnostic for beta-amyloid PET imaging   |                       |
| C9359   | Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Putty, Integra OS Osteoconductive Scaffold Putty), per 0.5cc | Effective 1/1/2022    |
| C9362   | Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Strip), per 0.5cc  | Effective 1/1/2022    |
| C9363   | Integra meshed bil wound mat   | Effective 1/1/2022    |

| CPT, HCPCS<br>or Revenue<br>Code   | Skin Substitutes Description  | Comments/ Limitations |
|--|---|-----------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. When requesting authorization for a skin grafting procedure, the material must be authorized or it may not be covered.</p> |   |                       |
| Q4101  | Apligraf, per square centimeter                                     |                       |
| Q4102  | Oasis wound matrix, per sq cm                                       |                       |
| Q4104  | Integra bilayer matrix wound dressing (bmwd), per square centimeter |                       |
| Q4105  | Integra dermal regeneration template (drt), per square centimeter   |                       |
| Q4107  | Graftjacket, per square centimeter                                  |                       |

| CPT, HCPCS<br>or Revenue<br>Code   | Skin Substitutes Description | Comments/ Limitations |
|--|------------------------------|-----------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. When requesting authorization for a skin grafting procedure, the material must be authorized or it may not be covered.</p> |                              |                       |
| Q4108  | Integra matrix, per sq cm    |                       |
| Q4110  | Primatrix                    | Effective 1/1/2022    |
| Q4111  | Gammagraft                   | Effective 1/1/2022    |
| Q4112  | Cymetra, injectable, 1cc     | Effective 1/1/2022    |
| Q4115  | Alloskin                     | Effective 1/1/2022    |

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|--|----------------------------------|-----------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. When requesting authorization for a skin grafting procedure, the material must be authorized or it may not be covered.</p> |                                  |                       |
| Q4116  | Alloderm, per square centimeter  |                       |
| Q4117  | Hyalomatrix                      | Effective 1/1/2022    |
| Q4121  | TheraSkin, per square centimeter |                       |
| Q4122  | Dermacell, awm, porous sq cm     |                       |
| Q4123  | Alloskin                         | Effective 1/1/2022    |

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|--|---|-----------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. When requesting authorization for a skin grafting procedure, the material must be authorized or it may not be covered.</p> |   |                       |
| Q4124  | Oasis ultra tri-layer wound matrix, per square centimeter |                       |
| Q4127  | Talymed   | Effective 1/1/2022    |
| Q4132  | Grafix core, per square centimeter                        |                       |
| Q4133  | Grafix prime, per square centimeter                       |                       |
| Q4134  | Hmatrix, per square centimeter                            |                       |

| CPT, HCPCS<br>or Revenue<br>Code   | Skin Substitutes Description          | Comments/ Limitations |
|--|---------------------------------------|-----------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. When requesting authorization for a skin grafting procedure, the material must be authorized or it may not be covered.</p> |                                       |                       |
| Q4135  | Mediskin, per square centimeter       |                       |
| Q4136  | Ez-derm, per square centimeter        |                       |
| Q4141  | Alloskin ac, 1cm                      | Effective 1/1/2022    |
| Q4142  | XCM biologic tissue matrix, per sq cm | Effective 1/1/2022    |
| Q4143  | Repriza, 1cm                          | Effective 1/1/2022    |

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|--|--------------------------------|-----------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. When requesting authorization for a skin grafting procedure, the material must be authorized or it may not be covered.</p> |                                |                       |
| Q4145  | EpiFix, injectable, 1mg        | Effective 1/1/2022    |
| Q4146  | Tensix, 1cm                    | Effective 1/1/2022    |
| Q4147  | Architect ecm px fx 1 sq cm    | Effective 1/1/2022    |
| Q4149  | Excellagen, 0.1cc              | Effective 1/1/2022    |
| Q4151  | AminoBand or guardian per sqcm |                       |

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|---|------------------------------|-----------------------|
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| Q4153   | Dermavest, plurivest sq cm   | Effective 1/1/2022    |
| Q4157   | Revitalon 1 square cm        | Effective 1/1/2022    |
| Q4158   | Kerecis omega3, per sq cm    | Effective 1/1/2022    |
| Q4161   | Bio-connekt per square cm    | Effective 1/1/2022    |
| Q4165   | Keramatrix, Kerasorb sq cm   | Effective 8/1/2020    |

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|--|------------------------------|-----------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. When requesting authorization for a skin grafting procedure, the material must be authorized or it may not be covered.</p> |                              |                       |
| Q4167  | Truskin, per sq centimeter   | Effective 1/1/2022    |
| Q4168  | AminoBand 1 mg               |                       |
| Q4169  | Artacent wound, per sq cm    | Effective 1/1/2022    |
| Q4171  | Interfyl, 1mg                | Effective 1/1/2022    |
| Q4175  | Miroderm                     | Effective 1/1/2022    |

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|--|------------------------------|-----------------------|
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| Q4176  | Neopatch, per sq centimeter  | Effective 1/1/2022    |
| Q4177  | FlowerAmnioFlo, 0.1cc        | Effective 1/1/2022    |
| Q4178  | Floweramniopatch, per sq cm  | Effective 1/1/2022    |
| Q4179  | Flowerderm, per sq cm        | Effective 1/1/2022    |
| Q4181  | Amnio wound, per square cm   | Effective 1/1/2022    |

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|---|---|-----------------------|
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| Q4182   | Transcyte per sqcm                                  |                       |
| Q4183   | Surgigraft, per square centimeter                   |                       |
| Q4184   | Cellesta or duo per sq cm                           |                       |
| Q4185   | Cellesta flowable amnion (25 mg per cc); per 0.5 cc |                       |
| Q4186   | EpiFix, per square centimeter                       |                       |

| CPT, HCPCS<br>or Revenue<br>Code   | Skin Substitutes Description       | Comments/ Limitations |
|--|------------------------------------|-----------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. When requesting authorization for a skin grafting procedure, the material must be authorized or it may not be covered.</p> |                                    |                       |
| Q4187  | Epicord, per square centimeter     |                       |
| Q4188  | Amnioarmor, per square centimeter  |                       |
| Q4190  | Artacent ac, per square centimeter |                       |
| Q4191  | Restorigin, per square centimeter  |                       |
| Q4194  | Novachor, per square centimeter    |                       |

| CPT, HCPCS<br>or Revenue<br>Code   | Skin Substitutes Description                     | Comments/ Limitations |
|--|--|-----------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. When requesting authorization for a skin grafting procedure, the material must be authorized or it may not be covered.</p> |  |                       |
| Q4197  | Puraply xt, per square centimeter                |                       |
| Q4198  | Genesis amniotic membrane, per square centimeter |                       |
| Q4199  | Cygnus matrix, per square centimeter             | Effective 9/1/2022    |
| Q4200  | Skin te, per square centimeter                   |                       |
| Q4201  | Matrion, per square centimeter                   |                       |

| CPT, HCPCS<br>or Revenue<br>Code   | Skin Substitutes Description      | Comments/ Limitations |
|--|-----------------------------------|-----------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. When requesting authorization for a skin grafting procedure, the material must be authorized or it may not be covered.</p> |                                   |                       |
| Q4202  | Keroxx (2.5g/cc), 1cc             |                       |
| Q4203  | Derma-gide, per square centimeter |                       |
| Q4206  | Fluid flow or fluid GF, 1 cc      | Effective 8/1/2020    |
| Q4208  | Novafix, per square centimeter    |                       |
| Q4209  | Surgraft, per square centimeter   |                       |

| CPT, HCPCS<br>or Revenue<br>Code   | Skin Substitutes Description                        | Comments/ Limitations |
|--|---|-----------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. When requesting authorization for a skin grafting procedure, the material must be authorized or it may not be covered.</p> |   |                       |
| Q4211  | Amnion bio or Axobiomembrane, per square centimeter |                       |
| Q4212  | Allogen, per cc                                     | Effective 8/1/2020    |
| Q4213  | Ascent, 0.5 mg                                      | Effective 8/1/2020    |
| Q4214  | Cellesta cord, per square centimeter                | Effective 8/1/2020    |
| Q4216  | Artacent cord, per square centimeter                | Effective 8/1/2020    |

| CPT, HCPCS<br>or Revenue<br>Code  | Skin Substitutes Description  | Comments/ Limitations |
|---|---|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. When requesting authorization for a skin grafting procedure, the material must be authorized or it may not be covered. |   |                       |
| Q4217   | Woundfix, BioWound, Woundfix Plus, BioWound Plus, Woundfix Xplus or BioWound Xplus, per square centimeter |                       |
| Q4218   | Surgicord, per square centimeter  |                       |
| Q4219   | Surgigraft-dual, per square centimeter  |                       |
| Q4220   | BellaCell HD or Surederm, per square centimeter   |                       |
| Q4221   | Amniowrap2, per square centimeter   |                       |

| CPT, HCPCS<br>or Revenue<br>Code   | Skin Substitutes Description  | Comments/ Limitations |
|--|---|-----------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. When requesting authorization for a skin grafting procedure, the material must be authorized or it may not be covered.</p> |   |                       |
| Q4224  | Human health factor 10 amniotic patch (hhf10-p), per square centimeter            | Effective 9/1/2022    |
| Q4225  | Amniobind or dermabind tl, per square centimeter                                  | Effective 9/1/2022    |
| Q4226  | MyOwn skin, includes harvesting and preparation procedures, per square centimeter |                       |
| Q4230  | Cogenex Flowable Amnion, per 0.5cc  | Effective 1/1/2022    |
| Q4232  | Corplex, per sq cm  | Effective 1/1/2022    |

| CPT, HCPCS<br>or Revenue<br>Code   | Skin Substitutes Description              | Comments/ Limitations |
|--|---|-----------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. When requesting authorization for a skin grafting procedure, the material must be authorized or it may not be covered.</p> |   |                       |
| Q4233  | SurFactor or NuDyn, per 0.5cc             | Effective 1/1/2022    |
| Q4237  | Cryo-Cord, per sq cm                      | Effective 1/1/2022    |
| Q4238  | Derm-Maxx, per sq cm                      | Effective 1/1/2022    |
| Q4240  | CoreCyte, for topical use only, per 0.5cc | Effective 1/1/2022    |
| Q4241  | PolyCyte, for topical use only, per 0.5cc | Effective 1/1/2022    |

| CPT, HCPCS<br>or Revenue<br>Code   | Skin Substitutes Description                     | Comments/ Limitations |
|--|--|-----------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. When requesting authorization for a skin grafting procedure, the material must be authorized or it may not be covered.</p> |  |                       |
| Q4242  | AmnioCyte Plus, per 0.5cc                        | Effective 1/1/2022    |
| Q4245  | AmnioText, per cc                                | Effective 1/1/2022    |
| Q4247  | Amniotext patch, per sq cm                       | Effective 1/1/2022    |
| Q4248  | Dermacyte Amniotic Membrane Allograft, per sq cm | Effective 1/1/2022    |
| Q4249  | AMNIPLY, for topical use only, per sq cm         | Effective 1/1/2022    |

| CPT, HCPCS<br>or Revenue<br>Code   | Skin Substitutes Description             | Comments/ Limitations |
|--|--|-----------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. When requesting authorization for a skin grafting procedure, the material must be authorized or it may not be covered.</p> |  |                       |
| Q4251  | Vim, per sq cm                           | Effective 1/1/2022    |
| Q4252  | Vendaje, per sq cm                       | Effective 1/1/2022    |
| Q4255  | REGUaRD, for topical use only, per sq cm | Effective 1/1/2022    |
| Q4256  | Mlg-complete, per square centimeter      | Effective 9/1/2022    |
| Q4257  | Relese, per square centimeter            | Effective 9/1/2022    |

| CPT, HCPCS<br>or Revenue<br>Code   | Skin Substitutes Description                                     | Comments/ Limitations |
|--|--|-----------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. When requesting authorization for a skin grafting procedure, the material must be authorized or it may not be covered.</p> |  |                       |
| Q4258  | Enverse, per square centimeter                                   | Effective 9/1/2022    |
| Q4259  | Celera dual layer or celera dual membrane, per square centimeter | Effective 7/1/2022    |
| Q4260  | Signature apatch, per square centimeter                          | Effective 7/1/2022    |
| Q4261  | Tag, per square centimeter                                       | Effective 7/1/2022    |
| Q4278  | Epieffect, per square centimeter                                 | Effective 10/1/2023   |

| CPT, HCPCS<br>or Revenue<br>Code   | Skin Substitutes Description                             | Comments/ Limitations |
|--|--|-----------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. When requesting authorization for a skin grafting procedure, the material must be authorized or it may not be covered.</p> |  |                       |
| Q4279  | Vendaje ac, per square centimeter                        | Effective 1/1/2024    |
| Q4280  | Xcell amnio matrix, per square centimeter                | Effective 10/1/2023   |
| Q4281  | Barrera sl or barrera dl, per square centimeter          | Effective 10/1/2023   |
| Q4282  | Cygnus dual, per square centimeter                       | Effective 10/1/2023   |
| Q4283  | Biovance tri-layer or biovance 3l, per square centimeter | Effective 10/1/2023   |

| CPT, HCPCS<br>or Revenue<br>Code   | Skin Substitutes Description         | Comments/ Limitations |
|--|--------------------------------------|-----------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. When requesting authorization for a skin grafting procedure, the material must be authorized or it may not be covered.</p> |                                      |                       |
| Q4284  | Dermabind sl, per square centimeter  | Effective 10/1/2023   |
| Q4285  | NuDYN DL or NuDYN DL MESH, per sq cm | Effective 1/1/2024    |
| Q4286  | NuDYN SL or NuDYN SLW, per sq cm     | Effective 1/1/2024    |
| Q4287  | Dermabind dl, per square centimeter  | Effective 1/1/2024    |
| Q4288  | Dermabind ch, per square centimeter  | Effective 1/1/2024    |

| CPT, HCPCS<br>or Revenue<br>Code   | Skin Substitutes Description                         | Comments/ Limitations |
|--|--|-----------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. When requesting authorization for a skin grafting procedure, the material must be authorized or it may not be covered.</p> |  |                       |
| Q4289  | Revoshield + amniotic barrier, per square centimeter | Effective 1/1/2024    |
| Q4290  | Membrane wrap-hydro, per square centimeter           | Effective 1/1/2024    |
| Q4291  | Lamellas xt, per square centimeter                   | Effective 1/1/2024    |
| Q4292  | Lamellas, per square centimeter                      | Effective 1/1/2024    |
| Q4293  | Acesso dl, per square centimeter                     | Effective 1/1/2024    |

| CPT, HCPCS<br>or Revenue<br>Code   | Skin Substitutes Description                   | Comments/ Limitations |
|--|--|-----------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. When requesting authorization for a skin grafting procedure, the material must be authorized or it may not be covered.</p> |  |                       |
| Q4294  | Amnio quad-core, per square centimeter         | Effective 1/1/2024    |
| Q4295  | Amnio tri-core amniotic, per square centimeter | Effective 1/1/2024    |
| Q4296  | Rebound matrix, per square centimeter          | Effective 1/1/2024    |
| Q4297  | Emerge matrix, per square centimeter           | Effective 1/1/2024    |
| Q4298  | Amnicore pro, per square centimeter            | Effective 1/1/2024    |

| CPT, HCPCS<br>or Revenue<br>Code  | Skin Substitutes Description           | Comments/ Limitations |
|---|--|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. When requesting authorization for a skin grafting procedure, the material must be authorized or it may not be covered. |  |                       |
| Q4299   | Amnicore pro+, per square centimeter   | Effective 1/1/2024    |
| Q4300   | Acesso tl, per square centimeter       | Effective 1/1/2024    |
| Q4301   | Activate matrix, per square centimeter | Effective 1/1/2024    |
| Q4302   | Complete aca, per square centimeter    | Effective 1/1/2024    |
| Q4303   | Complete aa, per square centimeter     | Effective 1/1/2024    |

| CPT, HCPCS<br>or Revenue<br>Code   | Skin Substitutes Description                        | Comments/ Limitations |
|--|---|-----------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. When requesting authorization for a skin grafting procedure, the material must be authorized or it may not be covered.</p> |   |                       |
| Q4304  | Grafix plus, per square centimeter                  | Effective 1/1/2024    |
| Q4305  | American amnion ac tri-layer, per square centimeter | Effective 4/1/24      |
| Q4306  | American amnion ac, per square centimeter           | Effective 4/1/24      |
| Q4307  | American amnion, per square centimeter              | Effective 4/1/24      |
| Q4308  | Sanopellis, per square centimeter                   | Effective 4/1/24      |

| CPT, HCPCS<br>or Revenue<br>Code   | Skin Substitutes Description        | Comments/ Limitations |
|--|-------------------------------------|-----------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. When requesting authorization for a skin grafting procedure, the material must be authorized or it may not be covered.</p> |                                     |                       |
| Q4309  | Via matrix, per square centimeter   | Effective 4/1/24      |
| Q4310  | Procenta, per 100 mg                | Effective 4/1/24      |
| Q4311  | Acesso, per square centimeter       | Effective 7/1/24      |
| Q4312  | Acesso ac, per square centimeter    | Effective 7/1/24      |
| Q4313  | Dermabind fm, per square centimeter | Effective 7/1/24      |

| CPT, HCPCS<br>or Revenue<br>Code   | Skin Substitutes Description                                  | Comments/ Limitations |
|--|---|-----------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. When requesting authorization for a skin grafting procedure, the material must be authorized or it may not be covered.</p> |   |                       |
| Q4314  | Reeva ft, per square cenitmeter                               | Effective 7/1/24      |
| Q4315  | Regenelink amniotic membrane allograft, per square centimeter | Effective 7/1/24      |
| Q4316  | Amchoplast, per square centimeter                             | Effective 7/1/24      |
| Q4317  | Vitograft, per square centimeter                              | Effective 7/1/24      |
| Q4318  | E-graft, per square centimeter                                | Effective 7/1/24      |

| CPT, HCPCS<br>or Revenue<br>Code   | Skin Substitutes Description      | Comments/ Limitations |
|--|-----------------------------------|-----------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. When requesting authorization for a skin grafting procedure, the material must be authorized or it may not be covered.</p> |                                   |                       |
| Q4319  | Sanograft, per square centimeter  | Effective 7/1/24      |
| Q4320  | Pellograft, per square centimeter | Effective 7/1/24      |
| Q4321  | Renograft, per square centimeter  | Effective 7/1/24      |
| Q4322  | Caregraft, per square centimeter  | Effective 7/1/24      |
| Q4323  | Alloply, per square centimeter    | Effective 7/1/24      |

| CPT, HCPCS<br>or Revenue<br>Code   | Skin Substitutes Description     | Comments/ Limitations |
|--|----------------------------------|-----------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. When requesting authorization for a skin grafting procedure, the material must be authorized or it may not be covered.</p> |                                  |                       |
| Q4324  | Amniotx, per square centimeter   | Effective 7/1/24      |
| Q4325  | Acapatch, per square centimeter  | Effective 7/1/24      |
| Q4326  | Woundplus, per square centimeter | Effective 7/1/24      |
| Q4327  | Duoamnion, per square centimeter | Effective 7/1/24      |
| Q4328  | Most, per square centimeter      | Effective 7/1/24      |

| CPT, HCPCS<br>or Revenue<br>Code   | Skin Substitutes Description        | Comments/ Limitations |
|--|-------------------------------------|-----------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. When requesting authorization for a skin grafting procedure, the material must be authorized or it may not be covered.</p> |                                     |                       |
| Q4329  | Singlay, per square centimeter      | Effective 7/1/24      |
| Q4330  | Total, per square centimeter        | Effective 7/1/24      |
| Q4333  | Ardeograft, per square centimeter   | Effective 7/1/24      |
| Q4334  | Amnioplast 1, per square centimeter | Effective 10/1/24     |
| Q4335  | Amnioplast 2, per square centimeter | Effective 10/1/24     |

| CPT, HCPCS<br>or Revenue<br>Code   | Skin Substitutes Description             | Comments/ Limitations |
|--|--|-----------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. When requesting authorization for a skin grafting procedure, the material must be authorized or it may not be covered.</p> |  |                       |
| Q4336  | Artacent c, per square centimeter        | Effective 10/1/24     |
| Q4337  | Artacent trident, per square centimeter  | Effective 10/1/24     |
| Q4338  | Artacent velos, per square centimeter    | Effective 10/1/24     |
| Q4339  | Artacent vericlen, per square centimeter | Effective 10/1/24     |
| Q4340  | Simpligraft, per square centimeter       | Effective 10/1/24     |

| CPT, HCPCS<br>or Revenue<br>Code  | Skin Substitutes Description   | Comments/ Limitations |
|---|--|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. When requesting authorization for a skin grafting procedure, the material must be authorized or it may not be covered. |  |                       |
| Q4341   | Simplimax, per square centimeter                                       | Effective 10/1/24     |
| Q4342   | Theramend, per square centimeter                                       | Effective 10/1/24     |
| Q4343   | Dermacyte ac matrix amniotic membrane allograft, per square centimeter | Effective 10/1/24     |
| Q4344   | Tri-membrane wrap, per square centimeter                               | Effective 10/1/24     |
| Q4346   | Shelter dm matrix, per square centimeter                               | Effective 1/1/25      |

| CPT, HCPCS<br>or Revenue<br>Code   | Skin Substitutes Description              | Comments/ Limitations |
|--|---|-----------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. When requesting authorization for a skin grafting procedure, the material must be authorized or it may not be covered.</p> |   |                       |
| Q4347  | Rampart dl matrix, per square centimeter  | Effective 1/1/25      |
| Q4348  | Sentry sl matrix, per square centimeter   | Effective 1/1/25      |
| Q4349  | Mantle dl matrix, per square centimeter   | Effective 1/1/25      |
| Q4350  | Palisade dm matrix, per square centimeter | Effective 1/1/25      |
| Q4351  | Enclose tl matrix, per square centimeter  | Effective 1/1/25      |

| CPT, HCPCS<br>or Revenue<br>Code   | Skin Substitutes Description  | Comments/ Limitations |
|--|---|-----------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. When requesting authorization for a skin grafting procedure, the material must be authorized or it may not be covered.</p> |   |                       |
| Q4352  | Overlay sl matrix, per square centimeter  | Effective 1/1/25      |
| Q4353  | Xceed tl matrix, per square centimeter  | Effective 1/1/25      |
| Q4354  | Palingen dual-layer membrane, per square centimeter                             | Effective 4/1/25      |
| Q4355  | Abiomend xplus membrane and abiomend xplus hydromembrane, per square centimeter | Effective 4/1/25      |
| Q4356  | Abiomend membrane and abiomend hydromembrane, per square centimeter             | Effective 4/1/25      |

| CPT, HCPCS<br>or Revenue<br>Code   | Skin Substitutes Description         | Comments/ Limitations |
|--|--------------------------------------|-----------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. When requesting authorization for a skin grafting procedure, the material must be authorized or it may not be covered.</p> |                                      |                       |
| Q4359  | Choriplay, per square centimeter     | Effective 4/1/25      |
| Q4360  | Amchoplast fd, per square centimeter | Effective 4/1/25      |
| Q4362  | Cygnus disk, per square centimeter   | Effective 4/1/25      |
| Q4367  | Amniocore sl, per square centimeter  | Effective 4/1/25      |
| Q4368  | Amchothick, per square centimeter    | Effective 7/1/25      |

| CPT, HCPCS<br>or Revenue<br>Code   | Skin Substitutes Description              | Comments/ Limitations |
|--|---|-----------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. When requesting authorization for a skin grafting procedure, the material must be authorized or it may not be covered.</p> |   |                       |
| Q4369  | Amnioplast 3, per square centimeter       | Effective 7/1/25      |
| Q4370  | Aeroguard, per square centimeter          | Effective 7/1/25      |
| Q4371  | Neoguard, per square centimeter           | Effective 7/1/25      |
| Q4372  | Amchoplast excel, per square centimeter   | Effective 7/1/25      |
| Q4373  | Membrane wrap lite, per square centimeter | Effective 7/1/25      |

| CPT, HCPCS<br>or Revenue<br>Code   | Skin Substitutes Description                 | Comments/ Limitations |
|--|--|-----------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. When requesting authorization for a skin grafting procedure, the material must be authorized or it may not be covered.</p> |  |                       |
| Q4375  | Duograft ac, per square centimeter           | Effective 7/1/25      |
| Q4376  | Duograft aa, per square centimeter           | Effective 7/1/25      |
| Q4377  | Trigraft ft, per square centimeter           | Effective 7/1/25      |
| Q4378  | Renew ft matrix, per square centimeter       | Effective 7/1/25      |
| Q4379  | Amniodefend ft matrix, per square centimeter | Effective 7/1/25      |

| CPT, HCPCS<br>or Revenue<br>Code   | Skin Substitutes Description          | Comments/ Limitations |
|--|---------------------------------------|-----------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. When requesting authorization for a skin grafting procedure, the material must be authorized or it may not be covered.</p> |                                       |                       |
| Q4380  | Advograft one, per square centimeter  | Effective 7/1/25      |
| Q4382  | Advograft dual, per square centimeter | Effective 7/1/25      |

| Code(s) | Cell/Gene Description   | Comments/<br>Limitations | Notes   |
|---------|---|--------------------------|---|
| Various | All Cell/Gene Therapy requires prior-authorization.   | Effective 5.1.21         |   |
| 38205   | Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection  | Effective 11.1.21        | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a> |
| 38206   | Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous  | Effective 11.1.21        | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a> |
| 38207   | Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage  | Effective 11.1.21        | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a> |
| 38208   | Transplant preparation of hematopoietic progenitor cells;   | Effective 1.1.25         | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a> |
| 38225   | Chimeric antigen receptor T-cell (CAR-T) therapy; harvesting of blood-derived T lymphocytes for development of genetically modified autologous CAR-T cells, per day | Effective 1.1.25         | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a> |
| 38226   | Chimeric antigen receptor T-cell (CAR-T) therapy; preparation of blood-derived T lymphocytes for transportation (eg, cryopreservation, storage)                     | Effective 1.1.25         | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a> |
| 38227   | Chimeric antigen receptor T-cell (CAR-T) therapy; receipt and preparation of CAR-T cells for administration   | Effective 1.1.25         | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a> |

| Code(s)             | Cell/Gene Description   | Comments/<br>Limitations                             | Notes   |
|---------------------|---|--|---|
| Various             | All Cell/Gene Therapy requires prior-authorization.   | Effective 5.1.21                                     |   |
| 38228               | Chimeric antigen receptor T-cell (CAR-T) therapy; CAR-T cell administration, autologous   | Effective 1.1.25                                     | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a>                         |
| 38241               | Hematopoietic progenitor cell (HPC); autologous transplantation   | Effective 11.1.21                                    | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a>                         |
| 88240               | Cryopreservation, freezing and storage of cells, each cell line   | Effective 11.1.21                                    | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a>                         |
| ** 96365 if >\$7500 | Hydration, Therapeutic, Prophylactic, Diagnostic Injections and Infusions, and Chemotherapy and Other Highly Complex Drug or Highly Co. | Effective 1/1/23 changed to \$7500 Effective 10.1.23 | <a href="#">Requests for prior authorization for this code if billing &gt; \$7500, should be sent to 586-693-4768. Click here for link to form.</a> |
| ** 96366 if >\$7500 | Hydration, Therapeutic, Prophylactic, Diagnostic Injections and Infusions, and Chemotherapy and Other Highly Complex Drug               | Effective 10.1.23                                    | <a href="#">Requests for prior authorization for this code if billing &gt; \$7500, should be sent to 586-693-4768. Click here for link to form.</a> |
| ** C9399 if >\$7500 | Unclassified drugs  | Effective 10.1.23                                    | <a href="#">Requests for prior authorization for this code if billing &gt; \$7500, should be sent to 586-693-4768. Click here for link to form.</a> |

| Code(s)             | Cell/Gene Description   | Comments/<br>Limitations                                | Notes   |
|---------------------|---|---|---|
| Various             | All Cell/Gene Therapy requires prior-authorization.   | Effective 5.1.21  |   |
| ** J3490 if >\$7500 | Unclassified drugs  | Effective 10.1.23                                       | <a href="#">Requests for prior authorization for this code if billing &gt; \$7500, should be sent to 586-693-4768. Click here for link to form.</a> |
| ** J3590 if >\$7500 | Unclassified drugs  | Effective 10.1.23                                       | <a href="#">Requests for prior authorization for this code if billing &gt; \$7500, should be sent to 586-693-4768. Click here for link to form.</a> |
| ** J9999 if >\$7500 | Not otherwise classified, antineoplastic drugs  | Effective 11.1.23                                       | <a href="#">Requests for prior authorization for this code if billing &gt; \$7500, should be sent to 586-693-4768. Click here for link to form.</a> |
| Q2058               | Aucatzyl (obecabtagene autoleucel) CAR-T. Any Code used for this therapy requires authorization)                                      | Effective 11.8.24<br>New code assigned effective 7/1/25 | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a>                         |
| J1411               | Hemgenix (Etranacogene Dezaparvovec-drib) Gene Therapy  | Effective 1.1.23<br>New code 4.1.23                     | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a>                         |
| J1412               | Roctavian (Valoctocogene Roxaparvovec or BMN 270) Gene Therapy (Miscellaneous codes require authorization when used for this therapy) | Effective 8.1.23.<br>New Code Assigned 1/1/24           | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a>                         |
| J1413               | Elevidys (delandistrogene moxeparvovec) Gene Therapy (Miscellaneous codes require authorization when used for this therapy)           | Effective 8.1.23.<br>New Code assigned 1/1/24           | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a>                         |

| Code(s) | Cell/Gene Description   | Comments/<br>Limitations   | Notes   |
|---------|---|--|---|
| Various | All Cell/Gene Therapy requires prior-authorization.   | Effective 5.1.21   |   |
| J1414   | Beqvez (fidanacogene maraleucel) Gene Therapy (Any Code used for this therapy requires authorization)                             | Effective 4.25.24.<br>New Code assigned 1.1.25                       | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a>                         |
| J3392   | Casgevvy (exagamglogene autotemcel) Gene Therapy. (Unclassified codes require authorization when used for this therapy)           | Effective 1.16.24<br>New Code assigned 1.1.25                        | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a>                         |
| J3393   | Zynteglo beti-cel (betbeglogene darolentivec) Gene Therapy. (Unclassified codes require authorization when used for this therapy) | Effective 1.1.23.<br>New code assigned 7.1.24                        | <a href="#">Requests for prior authorization for this therapy, regardless of code, should be sent to 586-693-4768. Click here for link to form.</a> |
| J3394   | Lyfgenia (lkovotibeglogene autotemcel). Gene Therapy. (Unclassified codes require authorization when used for this therapy)       | Effective 1.1.24.<br>New code assigned 7.1.24                        | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a>                         |
| J3398   | Luxterna (vortigene-neparvovec-ryzl) Gene Therapy   | Effective 11.1.21  | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a>                         |
| J3399   | Zolgensma (onasemnogene abeparvovec -xioi) Gene Therapy   | Effective 11.1.21  | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a>                         |
| J3401   | Vyjuvek (beremagene geperpavec) Gene Therapy. (Unclassified codes require authorization when used for this therapy)               | Effective 1.1.24.<br>New code assigned 1/1/24.<br>Added to PA 8.1.25 | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a>                         |

| Code(s) | Cell/Gene Description  | Comments/<br>Limitations                   | Notes   |
|---------|--|--|---|
| Various | All Cell/Gene Therapy requires prior-authorization.  | Effective 5.1.21                           |   |
| J7330   | MACI (Autologous Cultured Chondrocytes on a Porcine Collagen Membrane) Gene Therapy  | Effective 11.1.21                          | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a> |
| J9029   | Adstiladrin (Nadofaragene firadenovec-vncg) Gene Therapy. (Miscellaneous codes require authorization when used for this therapy) | Effective 1.1.23<br>New code 7.1.23        | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a> |
| J9325   | Imlygic (talimogene laherparepvec) Gene Therapy  | Effective 11.1.21                          | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a> |
| Q2040   | Kymriah (tisagenlecleucel) CAR-T   | Effective 5/1/21.<br>Code assigned 10/1/23 | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a> |
| Q2041   | Yescarta (axicabtagene ciloleucel) CAR-T   | Effective 11.1.21                          | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a> |
| Q2042   | Kymriah (tisagenlecleucel) CAR-T   | Effective 5/1/21.<br>Code assigned 11/1/21 | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a> |
| Q2043   | Provenge (sipuleucel-T) CAR-T  | Effective 11.1.21                          | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a> |

| Code(s) | Cell/Gene Description  | Comments/<br>Limitations                         | Notes   |
|---------|--|--|---|
| Various | All Cell/Gene Therapy requires prior-authorization.  | Effective 5.1.21                                 |   |
| Q2053   | Tecartus (Brexucabtagene autoleucel), up to 200 million autologous anti-CD19 CAR positive viable T cells including leukapheresis and dose preparation procedures per therapeutic dose . CAR-T  | Effective 11/1/2021                              | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a> |
| Q2054   | Breyanzi (lisocabtagene maraleucel) CAR-T  | Effective 11/1/21                                | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a> |
| Q2055   | Abecma (idecabtagene vicleucel) CAR-T  | Effective 11.1.21.<br>New code assigned 1/1/22   | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a> |
| Q2056   | Carvykti (Ciltacabtagene autoleucel) CAR-T   | Effective 7.1.22.<br>New Code effective 10.1.22. | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a> |
| Q2057   | Tecelra (Afamitresgene autoleucel) (CAR-T)   | Effective 8.1.24.<br>New code assigned 4.1.25    | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a> |
| S2140   | Cord blood harvesting for transplantation, allogeneic (Allocord; Clevecord;Ducord; Hemacord; HPC Cord Blood Clinimmune labs; HPC Cord Blood MD Anderson Blood Bank;HPC Cord Blood LifeSouth Community Blood Centers; HPC, Cord Blood Bloodworks. | Effective 11/1/21                                | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a> |
| TBD     | Amtagvi (Lifileucel) CAR-T   | Effective 2.21.24                                | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a> |

| Code(s) | Cell/Gene Description   | Comments/<br>Limitations                                   | Notes   |
|---------|---|--|---|
| Various | All Cell/Gene Therapy requires prior-authorization.   | Effective 5.1.21   |   |
| TBD     | Encelto (revakinagene taroretcel-lwey) (Gene Therapy)   | Not covered until requiring Authorization Effective 3.5.25 | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a>                         |
| TBD     | Gintuit (Allogeneic Cultured Keratinocytes and Fibroblasts in Bovine Collagen) CAR-T. (Unclassified codes require authorization when used for this therapy) | Effective 1.1.24   | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a>                         |
| TBD     | Kebilidi (eladocagene exuparvovec-tneq) (Gene Therapy)  | Effective 11.13.24   | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a>                         |
| TBD     | Lantrida (donislecel) CAR-T (Unclassified codes require authorization when used for this therapy)   | Effective 1.1.24   | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a>                         |
| TBD     | Laviv (azficel-T)   | Cosmetic. Not Covered                                      |   |
| J3391   | Lenmeldy (vortigene-neparvovec-ryzl) Gene Therapy. (Unclassified codes require authorization when used for this therapy)                                    | Effective 3.18.24. New Code assigned effective 7.1.25      | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a>                         |
| TBD     | Omisirge (omidubicel) CAR-T. (Unclassified codes require authorization when used for this therapy)  | Effective 1.1.24   | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a>                         |
| TBD     | Rethymic (Allogenic processed thymus tissue-agdc) Gene Therapy (Unclassified codes require authorization when used for this therapy)                        | Effective 10/1/23  | <a href="#">Requests for prior authorization for this therapy, regardless of code, should be sent to 586-693-4768. Click here for link to form.</a> |

| Code(s) | Cell/Gene Description   | Comments/<br>Limitations                                     | Notes   |
|---------|---|--|---|
| Various | All Cell/Gene Therapy requires prior-authorization.   | Effective 5.1.21   |   |
| TBD     | Ryoncil (remestemcel-L-rknd) (CAR-T)  | Not covered until requiring Authorization Effective 12.19.24 | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a>                         |
| TBD     | Skysona (Elivaldogene autotemcel FKA eli-cel) Autologous Gene Cell Therapy. (Unclassified codes require authorization when used for this therapy) | Effective 1.1.23   | <a href="#">Requests for prior authorization for this therapy, regardless of code, should be sent to 586-693-4768. Click here for link to form.</a> |
| TBD     | SYMVESS (acellular tissue engineered vessel-tyod) (CAR-T)   | Not covered until requiring Authorization Effective 12.19.24 | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a>                         |
| TBD     | Zevaskyn (prademagene zamikeracel, pz-cel) (Gene Therapy)   | Not covered until requiring Authorization Effective 4.29.25  | <a href="#">Requests for prior authorization for this code should be sent to 586-693-4768. Click here for link to form.</a>                         |
| **      | Codes in Orange require authorization if billing >\$7500.   | Effective 10.1.23  |   |

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|       |          |                |  |                              |  |
|-------|----------|----------------|--|------------------------------|--|
| J0129 | Orencia  | abatacept      | 1/1/2023   | Auto-inflammatory Conditions | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J0174 | LEQEMBI  | Lecanemab      | Covered effective 5/1/2024 with prior authorization. | Antidementia Agent           | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J0175 | KISUNLA  | donanemab-azbt | Covered effective 4/1/25 with prior authorization    | Alzheimer's Disease          | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J0177 | EYLEA HD | Afilbercept    | Covered effective 9/1/24 with prior authorization.   | Ophthalmic Disorders         | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J0178 | EYLEA    | Aflibercept    | 10/1/2022  | Macular Degeneration         | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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|-------|-----------|---------------------|---|----------------------------|--|
| J0179 | BEOVU     | Brolucizumab        | 10/1/2022   | Macular Degeneration       | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J0180 | FABRAZYME | Agalsidase beta     | 9/1/24  | Enzyme Deficiency          | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J0202 | Lemtrada  | alemtuzumab         | 1/1/2023  | Multiple Sclerosis         | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J0217 | LAMZEDE   | Velmanase alfa-tycv | Covered effective 9/1/24 with prior authorization.  | Enzyme Replacement Therapy | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J0218 | Xenpozyme | olipudase alfa-rpcp | Covered effective 1/1/2024 with Prior Authorization | Enzyme Deficiency          | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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|       |                    |                               |           |                         |  |
|-------|--------------------|-------------------------------|-----------|-------------------------|--|
| J0219 | NEXVIAZYME         | Avalglucosidase alfa-<br>ngpt | 10/1/2022 | Enzyme Deficiency       | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J0220 | Alglucosidase alfa | Alglucosidase alfa            | 10/1/2022 | Enzyme Deficiency       | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J0221 | LUMIZYME           | Alglucosidase alfa            | 10/1/2022 | Enzyme Deficiency       | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J0222 | ONPATTRO           | patisiran                     | 5/1/2023  | Amyloidosis             | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J0223 | GIVLAARI           | Givosiran                     | 9/1/24    | Acute Hepatic Porphyria | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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|       |                   |                               |   |  |  |
|-------|-------------------|-------------------------------|---|--|--|
| J0224 | OXLUMO            | Lumasiran                     | 9/1/24  | Primary Hyperoxaluria  | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J0225 | Amvuttra          | vutrisiran                    | 11/1/2023   | Hereditary Transthyretin (hATTR) Amyloidosis with Polyneuropathy | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J0401 | Abilify Maintena  | Aripiprazole                  | Not covered until 1/1/25 with Prior Authorization | Atypical Antipsychotic   | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J0402 | Abilify Asimtufii | Aripiprazole extended-release | Not covered until 1/1/25 with Prior Authorization | Atypical Antipsychotic   | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J0485 | Nulojix           | belatacept                    | 1/1/2023  | Immunosuppressive Agents   | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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|       |             |                  |   |   |  |
|-------|-------------|------------------|---|---|--|
| J0490 | Benlysta IV | belimumab        | 1/1/2023  | Systemic Lupus Erythematosus (SLE)          | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J0491 | Saphnelo    | anifrolumab-fnia | Covered effective 1/1/2024 with Prior Authorization | Systemic Lupus Erythematosus (SLE or Lupus) | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J0517 | FASENRA     | benralizumab     | 8/1/2022  | Asthma                                      | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J0565 | ZINPLAVA    | bezlotoxumab     | 8/1/2022  | Passive Immunizing and Treatment Agents     | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J0567 | BRINEURA    | cerliponase alfa | 1/1/2022  | Enzyme Deficiency                           | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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|       |          |                      |          |                      |  |
|-------|----------|----------------------|----------|----------------------|--|
| J0584 | Crysvita | burosumab            | 1/1/2023 | Metabolic Conditions | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J0585 | BOTOX    | onabotulinumtoxina   | 6/1/2022 | Neurotoxins          | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J0586 | DYSPORE  | abobotulinumtoxina   | 6/1/2022 | Neurotoxins          | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J0587 | MYOBLOC  | rimabotulinumtoxinb  | 6/1/2022 | Neurotoxins          | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J0588 | XEOMIN   | incobotulinumtoxin a | 6/1/2022 | Neurotoxins          | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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|       |           |                         |  |                                   |  |
|-------|-----------|-------------------------|--|-----------------------------------|--|
| J0589 | DAXXIFY   | Daxibotulinumtoxinalanm | Covered effective 9/1/24 with prior authorization. | Neurotoxins                       | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J0596 | Ruconest  | c1 esterase inhibitor   | Not covered until 11/1/25 with prior authorization | Acute Hereditary Angioedema (HAE) | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J0614 | Grafaplex | Treosulfan              | 3/1/2026   | Oncology                          | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J0638 | Ilaris    | canakinumab             | 1/1/2023   | Auto-inflammatory Conditions      | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J0717 | Cimzia    | certolizumab            | 1/1/2023   | Auto-inflammatory Conditions      | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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|       |         |                                       |   |   |  |
|-------|---------|---------------------------------------|---|---|--|
| J0775 | Xiaflex | collagenase, clostridium histolyticum | 1/1/2023  | Enzyme  | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J0791 | Adakveo | crizanlizumab-tmca                    | 1/1/2023  | Sickle Cell Disease                                   | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J0870 | RYTELO  | imetelstat                            | Covered effective 4/1/25 with prior authorization   | Oncology  | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J0879 | Korsuva | difelikefalin                         | Covered effective 1/1/2024 with Prior Authorization | Pruritis associated with chronic kidney disease (CKD) | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J0885 | EPOGEN  | epoetin alfa                          | 8/1/2022  | Anemia  | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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|-------|----------|-------------------|---|--------------------------|--|
| J0885 | PROCRIT  | epoetin alfa      | 8/1/2022  | Anemia                   | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J0887 | Mircera  | epoetin beta      | Precertification Notification 1/1/21-12/31/2024, Then covered 1/1/2025 with Prior Authorization | Anemia (Dialysis)        | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| j0888 | Mircera  | epoetin beta      | Precertification Notification 1/1/21-12/31/2024, Then covered 1/1/2025 with Prior Authorization | Anemia (Dialysis)        | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J0896 | Reblozyl | luspatercept-aamt | 1/1/2023  | Myelodysplastic Syndrome | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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|       |           |                           |  |                               |  |
|-------|-----------|---------------------------|--|-------------------------------|--|
| J0897 | PROLIA    | denosumab                 | 6/1/2022   | Osteoporosis                  | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J0897 | XGEVA     | denosumab                 | 8/1/2022   | Osteoporosis                  | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J1203 | POMBILITI | Cipaglicosidase alfa-atga | Covered effective 9/1/24 with prior authorization.                           | Enzyme Deficiency             | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J1299 | SOLIRIS   | eculizumab                | New code assigned 4/1/25. Previous code, J1300 required auth 1/1/22-.3/31/25 | Auto-inflammatory Conditions  | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J1301 | Radicava  | edaravone                 | 1/1/2023   | Amyotrophic Lateral Sclerosis | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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|-------|-----------|-----------------|---|-------------------------------------|--|
| J1302 | Enjaymo   | sutimlimab-jome | Covered effective 1/1/2024 with Prior Authorization | Anti-Inflammatory Conditions        | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J1303 | ULTOMIRIS | Ravulizumab     | 10/1/2022   | Auto-inflammatory Conditions        | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J1304 | QALSODY   | Tofersen        | Covered effective 9/1/24 with prior authorization.  | Amyotrophic Lateral Sclerosis (ALS) | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J1305 | Evkeeza   | evinacumab-dgnb | 11/1/2023   | Hypercholesterolemi<br>a            | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J1306 | LEQVIO    | Inclisiran      | 10/1/2022   | Hypercholesterolemi<br>a            | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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|-------|----------|-------------------|--|---|--|
| J1307 | PIASKY   | crovalimab-akkz   | Covered effective 4/1/25 with prior authorization  | Paroxysmal Nocturnal Hemoglobinuria (PNH) | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J1322 | VIMIZIM  | Elosulfase alfa   | Precertification Notification 1/1/21-8/31/2024, Then covered 9/1/2024 with Prior Authorization | Enzyme Deficiency                         | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J1323 | ELREXFIO | Elranatamab-bcmm  | Covered effective 9/1/24 with prior authorization.   | Oncology                                  | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J1326 | Vyloy    | zolbetuximab-clzb | Not covered until 11/1/25 with prior authorization   | Oncology                                  | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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|-------|------------|-------------|---|-----------------------------------|---|
| J1426 | AMONDYS 45 | Casimersen  | Prior to 12/31/23 required medical PA. Effective 1/1/24 requires Medical Specialty Pharmacy Prior Authorization | Duchenne Muscular Dystrophy       | <a href="#">After 1/1/24 Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J1427 | Viltepso   | viltolarsen | Precertification Notification 1/1/21-12/31/2023, Then covered 1/1/2024 with Prior Authorization                 | Duchenne Muscular Dystrophy (DMD) | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a>              |
| J1428 | Exondys 51 | eteplirsen  | Precertification Notification 1/1/21-12/31/2023, Then covered 1/1/2024 with Prior Authorization                 | Duchenne Muscular Dystrophy (DMD) | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a>              |
| J1429 | Vyondys 53 | golodirsen  | Precertification Notification 1/1/21-12/31/2023, Then covered 1/1/2024 with Prior Authorization                 | Duchenne Muscular Dystrophy (DMD) | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a>              |

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To see a product list of physician-administered specialty medications or infusion therapies along with coverage and notification information please visit the

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|-------|------------|--|---|------------------------------|--|
| J1437 | MONOFERRIC | Ferric derisomaltose                     | 10/1/2022   | Anemia                       | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J1438 | ENBREL     | etanercept                               | 8/1/2022  | Auto-inflammatory Conditions | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J1439 | INJECTAFER | Ferric carboxymaltose                    | 10/1/2022   | Anemia                       | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J1442 | NEUPOGEN   | filgrastim (g-csf), excludes biosimilars | 8/1/2022  | Neutropenia                  | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J1449 | Rolvedon   | eflapegrastim-xnst                       | Covered effective 1/1/2024 with Prior Authorization | Anemia                       | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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|-------|-----------|----------------------------|---|-------------------|--|
| J1454 | Akynzeo   | fosnetupitant/palonosetron | Precertification Notification 8/1/21-12/31/2023, Then covered 1/1/2024 with Prior Authorization     | Immunodeficiency  | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J1458 | Naglazyme | galsulfase                 | 1/1/2023  | Enzyme Deficiency | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J1459 | PRIVIGEN  | immune globulin            | Requires Precertification Notification 1/1/21-4/30/24. Requires Prior Authorization as of 5/1/2024. | Immunodeficiency  | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J1551 | Cutaquig  | immune globulin            | Covered effective 1/1/2024 with Prior Authorization   | Immunodeficiency  | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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|-------|----------|-----------------|---|------------------|--|
| J1552 | ALYGLO   | immune globulin | Covered effective 4/1/25 with prior authorization   | Immunodeficiency | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J1555 | CUVITRU  | immune globulin | Precertification Notification 1/1/21-12/31/2023, Then covered 1/1/2024 with Prior Authorization | Immunodeficiency | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J1558 | XEMBIFY  | immune globulin | Precertification Notification 1/1/21-12/31/2023, Then covered 1/1/2024 with Prior Authorization | Immunodeficiency | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J1559 | Hizentra | immune globulin | Precertification Notification 1/1/21-12/31/2023, Then covered 1/1/2024 with Prior Authorization | Immunodeficiency | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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|-------|-----------|-----------------|---|------------------|--|
| J1561 | GAMMAKED  | immune globulin | Requires Precertification Notification 1/1/21-4/30/24. Requires Prior Authorization as of 5/1/2024. | Immunodeficiency | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J1561 | GAMUNEX-C | immune globulin | Requires Precertification Notification 1/1/21-4/30/24. Requires Prior Authorization as of 5/1/2024. | Immunodeficiency | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J1568 | Octagam   | immune globulin | Precertification Notification 1/1/21-12/31/2024, Then covered 1/1/2025 with Prior Authorization     | Immunodeficiency | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J1569 | Gammagard | immune globulin | Precertification Notification 1/1/21-10/31/2023, Then covered 11/1/2024 with Prior Authorization    | Immunodeficiency | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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|-------|--------------|-------------------------------|---|------------------------------|--|
| J1575 | Hyqvia       | immune globulin/hyaluronidase | Precertification Notification 1/1/21-12/31/2023, Then covered 1/1/2024 with Prior Authorization | Immunodeficiency             | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J1602 | Simponi Aria | golimumab                     | 1/1/2023  | Auto-inflammatory Conditions | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J1627 | SUSTOL       | granisetron, extended-release | 8/1/2022  | Antiemetics                  | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J1628 | Tremfya      | guselkumab                    | 1/1/2023  | Auto-inflammatory Conditions | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J1743 | ELAPRASE     | idursulfase                   | 5/1/2023  | Enzyme Deficiency            | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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|-------|------------|---------------------------------|---|------------------------------|--|
| J1745 | INFLIXIMAB | infliximab, excludes biosimilar | 8/1/2022  | Auto-inflammatory Conditions | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J1745 | REMICADE   | infliximab, excludes biosimilar | 8/1/2022  | Auto-inflammatory Conditions | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J1746 | TROGARZO   | ibalizumab-uiyk                 | 5/1/2023  | HIV/AIDS                     | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J1747 | Spevigo    | spesolimab-sbzo                 | Covered effective 1/1/2024 with Prior Authorization | Anti-Inflammatory Conditions | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J1786 | CEREZYME   | Imiglucerase                    | 10/1/2022   | Enzyme Deficiency            | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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|-------|------------------|---|--|--------------------------------|--|
| J1809 | Nulibry          | Fosdenopterin                           | 3/1/2026   | Molybdenum Cofactor Deficiency | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J1823 | Uplizna          | inebilizumab-cdon                       | 1/1/2023   | Auto-inflammatory Conditions   | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J1930 | Somatuline Depot | Ilanreotide                             | 1/1/2023   | Endocrine Disorders            | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J1931 | ALDURAZYME       | Laronidase                              | Precertification Notification 1/1/21-8/31/2024, Then covered 9/1/2024 with Prior Authorization | Enzyme Deficiency              | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J1943 | Aristada Initio  | Aripiprazole lauroxil, (aristada), 1 mg | Not covered until 1/1/25 with Prior Authorization  | Atypical Antipsychotic         | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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|-------|----------|-----------------------|--|------------------------|--|
| J1944 | Aristada | Aripiprazole lauroxil | Not covered until 1/1/25 with Prior Authorization    | Atypical Antipsychotic | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J2182 | NUCALA   | mepolizumab           | 8/1/2022   | Asthma                 | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J2267 | Omvoh IV | mirikizumab-mrkz      | Covered effective 11/1/2024 with Prior Authorization | Ulcerative Colitis     | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J2277 | APHEXDA  | Motixafortide         | Covered effective 9/1/24 with prior authorization.   | Multiple Myeloma       | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J2323 | TYSABRI  | Natalizumab           | 10/1/2022  | Multiple Sclerosis     | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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| J2326 | SPINRAZA       | Nusinersen                     | 10/1/2022   | Spinal Muscular Atrophy      | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J2327 | Skyrizi        | risankizumab                   | 11/1/2023   | Anti-Inflammatory Conditions | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J2329 | Briumvi        | ublituximab-xiiy               | Covered effective 1/1/2024 with Prior Authorization               | Multiple Sclerosis (MS)      | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J2350 | OCREVUS        | Ocrelizumab                    | 10/1/2022   | Multiple Sclerosis           | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J2351 | Ocrevus Zunovo | ocrelizumab/hyaluronidase-ocsq | Not Covered until 8/1/2025, Then covered with Prior Authorization | Multiple Sclerosis           | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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|-------|-----------------------|-------------------------|---|------------------------|--|
| J2353 | SandoSTATIN LAR Depot | octreotide depot        | 1/1/2023  | Endocrine Disorders    | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J2356 | Tezspire              | tezepelumab-ekko        | 1/1/2023  | Asthma                 | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J2357 | XOLAIR                | omalizumab              | 8/1/2022  | Asthma                 | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J2358 | Zyprexa Relprevv      | Olanzapine, long-acting | Not covered until 1/1/25 with Prior Authorization | Atypical Antipsychotic | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J2425 | Kepivance             | palifermin              | 1/1/2023  | Oncology               | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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|-------|-----------------------|---|--|------------------------------|--|
| J2426 | Invega Sustenna       | Paliperidone palmitate extended release (invega sustenna) | Not covered until 1/1/25 with Prior Authorization  | Atypical Antipsychotic       | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J2427 | Invega Hafyera/Trinza | Paliperidone palmitate extended release                   | Not covered until 1/1/25 with Prior Authorization  | Atypical Antipsychotic       | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J2428 | Erzofri               | paliperidone palmitate                                    | Not covered until 11/1/25 with prior authorization | Atypical Antipsychotic       | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J2506 | NEULASTA              | pegfilgrastim, excludes biosimilar                        | 8/1/2022   | Neutropenia                  | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J2507 | Krystexxa             | pegloticase   | 1/1/23   | Auto-inflammatory Conditions | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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| J2508 | ELFABRIO | Pegunigalsidase alfa-<br>iwxj | Covered effective 9/1/24 with prior authorization.   | Enzyme Replacement Therapy (ERT) | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J2777 | Vabysmo  | faricimab-svoa                | Covered effective 1/1/2024 with Prior Authorization  | Macular Degeneration             | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J2778 | LUCENTIS | ranibizumab                   | 8/1/2022   | Macular Degeneration             | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J2781 | SYFOVRE  | pegcetacoplan (intravitreal)  | Precertification Notification 1/1/24-8/31/2024, Then covered 9/1/2024 with Prior Authorization | Ophthalmic Disorders             | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J2782 | IZERVAY  | Avacincaptad Pegol            | Covered effective 9/1/24 with prior authorization.   | Ophthalmic Disorders             | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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| J2783 | ELITEK           | Rasburicase                  | Precertification Notification 1/1/21-8/31/2024, Then covered 9/1/2024 with Prior Authorization | Chemo Protectant (TLS) | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J2786 | CINQAIR          | reslizumab                   | 8/1/2022   | Asthma                 | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J2794 | Risperdal Consta | Risperidone, long acting     | Not covered until 1/1/25 with Prior Authorization  | Atypical Antipsychotic | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J2799 | Uzedy            | risperidone extended release | Not covered until 1/1/25 with Prior Authorization  | Atypical Antipsychotic | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J2801 | Rykindo          | Risperidone extended release | Not covered until 1/1/25 with Prior Authorization  | Atypical Antipsychotic | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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| J2802 | Nplate  | romiplostim     | Effective 1/1/23. New Code assigned 1/1/25   | Thrombocytopenia  | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J2840 | KANUMA  | Sebelipase alfa | Precertification Notification 1/1/21-8/31/2024, Then covered 9/1/2024 with Prior Authorization | Enzyme Deficiency | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J2860 | SYLVANT | Siltuximab      | Precertification Notification 1/1/21-8/31/2024, Then covered 9/1/2024 with Prior Authorization | Oncology          | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J3032 | VYEPTI  | Eptinezumab     | 10/1/2022  | Migraine          | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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|-------|---------|--------------------|--|------------------------------|--|
| J3055 | TALVEY  | Talquetamab-tgvs   | Covered effective 9/1/24 with prior authorization. | Oncology                     | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J3060 | ELELYSO | Taliglucerase Alfa | 10/1/2022  | Enzyme Deficiency            | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J3111 | Evenity | romosozumab        | 1/1/2023   | Osteoporosis                 | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J3241 | TEPEZZA | teprotumumab-trbw  | 8/1/2022   | Thyroid Eye Disease          | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J3245 | Ilumya  | tildrakizumab      | 1/1/2023   | Auto-inflammatory Conditions | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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| J3247 | Cosentyx IV | secukinumab      | Covered effective 11/1/2024 with Prior Authorization   | Auto-inflammatory Conditions          | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J3262 | Actemra     | tocilizumab      | 1/1/2023   | Auto-inflammatory Conditions          | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J3263 | Loqtorzi    | toripalimab-tpzi | Covered effective 11/1/2024 with Prior Authorization   | Oncology                              | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J3285 | Remodulin   | treprostinil     | Precertification Notification 1/1/21-10/31/2023, Then covered 11/1/2024 with Prior Authorization | Pulmonary Arterial Hypertension (PAH) | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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| J3285 | Remodulin  | treprostinil       | Precertification Notification 1/1/21-10/31/2023, Then covered 11/1/2024 with Prior Authorization | Pulmonary Arterial Hypertension (PAH) | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J3357 | STELARA SC | Ustekinumab        | 10/1/2022  | Auto-inflammatory Conditions          | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J3358 | STELARA IV | Ustekinumab        | 10/1/2022  | Auto-inflammatory Conditions          | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J3380 | ENTYVIO    | Vedolizumab        | 10/1/2022  | Auto-inflammatory Conditions          | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J3385 | VPRIV      | Velaglucerase Alfa | 10/1/2022  | Enzyme Deficiency                     | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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| J3396 | Visudyne | verteporfin                | 1/1/2023   | Ophthalmic Disorders                                  | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J3397 | MEPSEVII | Vestronidase alfa-vjkb     | Precertification Notification 1/1/21-8/31/2024, Then covered 9/1/2024 with Prior Authorization | Enzyme Deficiency                                     | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J7170 | HEMLIBRA | Emicizumab                 | 10/1/2022  | Hemophilia  | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J7171 | Adzynma  | adamts13, recombinant-krhn | Covered effective 11/1/2024 with Prior Authorization   | Congenital Thrombotic Thrombocytopenic Purpura (cTTP) | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J7172 | Hypnavzi | marstacimab-hncq           | Not covered until 11/1/25 with prior authorization   | Hemophilia  | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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|------|-------------------------|----------------|-------------------|------|
|------|-------------------------|----------------|-------------------|------|

To see a product list of physician-administered specialty medications or infusion therapies along with coverage and notification information please visit the

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|       |          |   |  |            |  |
|-------|----------|---|--|------------|--|
| J7173 | Alhemo   | concizumab-mtci                                 | 3/1/2026   | Hemophilia | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J7174 | Qfitlia  | Ffitusiran                                      | 3/1/2026   | Hemophilia | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J7179 | Vonvendi | von willebrand factor (recombinant), (vonvendi) | Precertification Notification 1/1/21-12/31/2024, Then covered 1/1/2025 with Prior Authorization  | Hemophilia | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J7201 | Alprolix | factor ix, fc fusion protein                    | Precertification Notification 1/1/21-10/31/2023, Then covered 11/1/2024 with Prior Authorization | Hemophilia | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

| Code | Medical Specialty Drugs | Effective Date | Clinical Category | Note |
|------|-------------------------|----------------|-------------------|------|
|------|-------------------------|----------------|-------------------|------|

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|       |             |  |   |                      |  |
|-------|-------------|--|---|----------------------|--|
| J7209 | Nuwiq       | factor viii, (antihemophilic factor, recombinant)                    | Precertification Notification 1/1/21-12/31/2024, Then covered 1/1/2025 with Prior Authorization | Hemophilia           | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J7214 | ALTUVIIIIO  | antihemophilic factor (recombinant), Fc-VWF-XTEN fusion protein-ehtl | Covered effective 4/1/25 with prior authorization   | Hemophilia           | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J7313 | Iluvien     | iluvien  | 1/1/2023  | Ophthalmic Disorders | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J7318 | DUROLANE    | Hyaluronan or derivative   | 10/1/2022   | Osteoarthritis       | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J7320 | GENVISC 850 | Hyaluronan or derivative   | 10/1/2022   | Osteoarthritis       | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

| Code | Medical Specialty Drugs | Effective Date | Clinical Category | Note |
|------|-------------------------|----------------|-------------------|------|
|------|-------------------------|----------------|-------------------|------|

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|       |           |                          |           |                |  |
|-------|-----------|--------------------------|-----------|----------------|--|
| J7322 | HYMOVIS   | Hyaluronan or derivative | 10/1/2022 | Osteoarthritis | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J7324 | ORTHOVISC | Hyaluronan or derivative | 10/1/2022 | Osteoarthritis | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J7326 | GEL-ONE   | Hyaluronan or derivative | 10/1/2022 | Osteoarthritis | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J7327 | MONOVISC  | Hyaluronan or derivative | 10/1/2022 | Osteoarthritis | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J7328 | GELSYN-3  | Hyaluronan or derivative | 10/1/2022 | Osteoarthritis | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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|------|-------------------------|----------------|-------------------|------|
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|       |          |                              |  |                      |  |
|-------|----------|------------------------------|--|----------------------|--|
| J7329 | TRIVISC  | Hyaluronan or derivative     | 10/1/2022  | Osteoarthritis       | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J7332 | TRILURON | Hyaluronan or derivative     | 10/1/2022  | Osteoarthritis       | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J7355 | iDose TR | travoprost                   | Covered effective 11/1/2024 with Prior Authorization | Ophthalmic Disorders | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J7356 | Vyalev   | foscarbidopa and foslevodopa | Not covered until 11/1/25 with prior authorization   | Parkinson's Disease  | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9011 | Datroway | datopotamab deruxtecan-dlnk  | 3/1/2026   | Oncology             | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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|       |           |              |  |                   |  |
|-------|-----------|--------------|--|-------------------|--|
| J9019 | Erwinaze  | Asparaginase | Precertification Notification 1/1/21-12/31/2024, Then covered 1/1/2025 with Prior Authorization  | Oncology          | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9021 | Rylaze    | asparaginase | Covered effective 1/1/2024 with Prior Authorization  | Enzyme Deficiency | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9022 | Tecentriq | atezolizumab | 1/1/2023   | Oncology          | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9023 | Bavencio  | avelumab     | Precertification Notification 1/1/21-10/31/2023, Then covered 11/1/2024 with Prior Authorization | Oncology          | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

| Code | Medical Specialty Drugs | Effective Date | Clinical Category | Note |
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|------|-------------------------|----------------|-------------------|------|

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|       |                   |                                     |  |          |  |
|-------|-------------------|-------------------------------------|--|----------|--|
| J9024 | Tecentriq Hybreza | atezolizumab and hyaluronidase-tqjs | Not Covered until 8/1/2025, Then covered with Prior Authorization                              | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9025 | VIDAZA            | Azacitidine                         | Precertification Notification 1/1/21-8/31/2024, Then covered 9/1/2024 with Prior Authorization | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9026 | IMDELLTRA         | tarlatamab-dlle                     | Covered effective 4/1/25 with prior authorization  | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9027 | CLOLAR            | Clofarabine                         | Precertification Notification 1/1/21-8/31/2024, Then covered 9/1/2024 with Prior Authorization | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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|       |          |                                   |   |          |  |
|-------|----------|-----------------------------------|---|----------|--|
| J9028 | ANKTIVA  | nogapendekin alfa inbakicept-pmln | Covered effective 4/1/25 with prior authorization   | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9033 | Treanda  | bendamustine hcl                  | 1/1/2023  | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9034 | BENDEKA  | Bendamustine                      | Precertification Notification 1/1/21-12/31/2023, Then covered 1/1/2024 with Prior Authorization | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9036 | Belrapzo | bendamustine hcl                  | Precertification Notification 1/1/21-12/31/2023, Then covered 1/1/2024 with Prior Authorization | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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|       |          |                 |  |                                   |  |
|-------|----------|-----------------|--|-----------------------------------|--|
| J9038 | Niktimvo | axatilimab-csfr | Not Covered until 8/1/2025, Then covered with Prior Authorization                              | Chronic Graft-versus-Host Disease | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9039 | BLINCYTO | blinatumomab    | 1/1/2022   | Oncology                          | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9041 | Velcade  | bortezomib      | 1/1/2023   | Oncology                          | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9042 | Adcetris | brentuximab     | 1/1/2023   | Oncology                          | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9043 | JEVTANA  | Cabazitaxel     | Precertification Notification 1/1/21-8/31/2024, Then covered 9/1/2024 with Prior Authorization | Oncology                          | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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|       |           |                                   |  |          |  |
|-------|-----------|-----------------------------------|--|----------|--|
| J9047 | Kyprolis  | carfilzomib                       | 1/1/2023   | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9054 | Boruzu    | bortezomib (boruzu),<br>0.1 mg    | Not Covered until<br>8/1/2025, Then<br>covered with Prior<br>Authorization | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9055 | Erbix     | cetuximab                         | 1/1/2023   | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9061 | Rybrevant | amivantamab-vmjw                  | 11/1/2023  | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9063 | Elahere   | mirvetuximab<br>soravtansine-gynx | Covered effective<br>1/1/2024 with Prior<br>Authorization                  | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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|       |                 |                                  |   |          |  |
|-------|-----------------|----------------------------------|---|----------|--|
| J9119 | Libtayo         | cemiplimab-rwlc                  | 1/1/2023  | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9144 | Darzalex Faspro | daratumumab / hyaluronidase-fihj | 1/1/2023  | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9145 | Darzalex        | daratumumab                      | 1/1/2023  | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9155 | Firmagon        | degarelix                        | 1/1/2023  | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9161 | Lymphir         | denileukin diftitox-cxdl         | Not Covered until 8/1/2025, Then covered with Prior Authorization | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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|       |           |                         |  |          |  |
|-------|-----------|-------------------------|--|----------|--|
| J9173 | Imfinzi   | durvalumab              | 1/1/2023   | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9174 | Beizray   | docetaxel               | Not covered until 11/1/25 with prior authorization   | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9176 | Empliciti | elotuzumab              | 1/1/2023   | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9177 | PADCEV    | Enfortumab vedotin-ejfv | Precertification Notification 1/1/21-8/31/2024, Then covered 9/1/2024 with Prior Authorization | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9179 | Halaven   | eribulin mesylate       | 1/1/2023   | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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|       |           |                       |   |          |  |
|-------|-----------|-----------------------|---|----------|--|
| J9198 | INFUGEM   | Gemcitabine hcl       | Precertification Notification 1/1/21-8/31/2024, Then covered 9/1/2024 with Prior Authorization  | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9202 | Zoladex   | goserelin acetate     | Precertification Notification 1/1/21-12/31/2023, Then covered 1/1/2024 with Prior Authorization | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9203 | MYLOTARG  | gemtuzumab ozogamicin | 5/1/2023  | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9204 | Poteligeo | mogamulizumab-kpkc    | 1/1/2023  | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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|       |           |                       |  |                               |  |
|-------|-----------|-----------------------|--|-------------------------------|--|
| J9205 | ONIVYDE   | irinotecan liposome   | Covered through 3/31/25. As of 4/1/25 prior authorization is required.                         | Oncology                      | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9206 | CAMPTOSAR | Irinotecan (HCL)      | Precertification Notification 1/1/21-8/31/2024, Then covered 9/1/2024 with Prior Authorization | Oncology                      | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9216 | Actimmune | Interferon, gamma 1-b | Not covered until 1/1/25 with Prior Authorization  | Chronic Granulomatous Disease | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9223 | Zepzelca  | lurbinectedin         | 1/1/2023   | Oncology                      | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9227 | SARCLISA  | isatuximab-irfc       | 5/1/2023   | Oncology                      | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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|       |          |                           |  |          |  |
|-------|----------|---------------------------|--|----------|--|
| J9228 | Yervoy   | ipilimumab                | 1/1/2023   | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9229 | Besponsa | inotuzumab ozogamicin     | 1/1/2023   | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9248 | HEPZATO  | Melphalan                 | Covered effective 9/1/24 with prior authorization.   | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9262 | SYNRIBO  | Omacetaxine mepesuccinate | Precertification Notification 1/1/21-8/31/2024, Then covered 9/1/2024 with Prior Authorization | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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|       |          |                          |   |          |  |
|-------|----------|--------------------------|---|----------|--|
| J9264 | Abraxane | paclitaxel protein-bound | Precertification Notification 1/1/21-12/31/2023, Then covered 1/1/2024 with Prior Authorization | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9266 | Oncaspar | Pegaspargase             | Precertification Notification 1/1/21-12/31/2024, Then covered 1/1/2025 with Prior Authorization | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9269 | ELZONRIS | tagraxofusp-erzs         | 5/1/2023  | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9271 | KEYTRUDA | pembrolizumab            | 8/1/2022  | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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|       |          |                        |   |          |  |
|-------|----------|------------------------|---|----------|--|
| J9272 | JEMPERLI | Dostarlimab-gxly       | Covered effective 9/1/24 with prior authorization.  | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9273 | Tivdak   | tisotumab vedotin-tftv | Covered effective 1/1/2024 with Prior Authorization | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9274 | KIMMTRAK | tebentafusp-tebn       | 1/1/2023  | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9275 | Unloxcyt | cosibelimab-ipdl       | Not covered until 11/1/25 with prior authorization  | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9276 | Ziihera  | zanidatamab-hrii       | Not covered until 11/1/25 with prior authorization  | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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|-------|----------------|----------------------------------|---|----------|--|
| J9286 | Columvi        | glofitamab-gxbm                  | Covered effective 1/1/2024 with Prior Authorization | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9289 | Opdivo Qvantig | nivolumab and hyaluronidase-nvhy | Not covered until 11/1/25 with prior authorization  | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9298 | Opdualag       | nivolumab/relatlimab             | 11/1/2023   | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9299 | OPDIVO         | nivolumab                        | 8/1/2022  | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9301 | Gazyva         | obinutuzumab                     | 1/1/2023  | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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|       |          |              |   |          |  |
|-------|----------|--------------|---|----------|--|
| J9302 | Arzerra  | ofatumumab   | 1/1/2023  | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9303 | Vectibix | panitumumab  | 1/1/2023  | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9305 | Alimta   | pemetrexed   | Precertification Notification 1/1/21-12/31/2023, Then covered 1/1/2024 with Prior Authorization | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9306 | PERJETA  | Pertuzumab   | 10/1/2022   | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9307 | FOLOTYN  | pralatrexate | 1/1/2022  | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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|       |                |   |  |          |  |
|-------|----------------|---|--|----------|--|
| J9308 | Cyramza        | ramucirumab                                   | 1/1/2023   | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9309 | POLIVY         | polatuzumab vedotin-piiq                      | Precertification Notification 1/1/21-8/31/2024, Then covered 9/1/2024 with Prior Authorization | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9311 | RITUXAN HYCELA | rituximab / hyaluronidase                     | 8/1/2022   | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9312 | RITUXAN        | rituximab                                     | 8/1/2022   | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9316 | PHESGO         | pertuzumab / trastuzumab / hyaluronidase-zzxf | 8/1/2022   | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

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|       |          |                            |  |                        |  |
|-------|----------|----------------------------|--|------------------------|--|
| J9317 | Trodelvy | sacituzumab govitecan-hziy | 1/1/2023   | Oncology               | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9321 | Epkinly  | epcoritamab-bysp           | Effective 1/1/24   | Oncology               | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9329 | TEVIMBRA | tislelizumab-jsgr          | Covered effective 4/1/25 with prior authorization  | Oncology               | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9332 | Vyvgart  | efgartigimod alfa-fcab     | Covered effective 1/1/2024 with Prior Authorization  | Myasthenia Gravis (MG) | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9333 | RYSTIGGO | Rozanolixizumab-noli       | Precertification Notification 1/1/2024 - 8/31/2024 then with prior authorization effective 9/1/2024. | Myasthenia Gravis      | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

| Code | Medical Specialty Drugs | Effective Date | Clinical Category | Note |
|------|-------------------------|----------------|-------------------|------|
|------|-------------------------|----------------|-------------------|------|

To see a product list of physician-administered specialty medications or infusion therapies along with coverage and notification information please visit the

[Medical Benefit Drug Formulary List on SmartHealth Pharmacy Page](#)

|       |                 |  |  |                   |  |
|-------|-----------------|--|--|-------------------|--|
| J9334 | VYVGART HYTRULO | Efgartigimod alfa, 2 mg and Hyaluronidase-qvfc | Precertification Notification 1/1/2024 - 8/31/2024 then with prior authorization effective 9/1/2024. | Myasthenia Gravis | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9341 | Tepylute        | thiotepa                                       | Not covered until 11/1/25 with prior authorization   | Oncology          | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9345 | ZYNYZ           | Retifanlimab-dlwr                              | Covered effective 9/1/24 with prior authorization.   | Oncology          | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9347 | Imjudo          | tremelimumab-actl                              | Covered effective 1/1/2024 with Prior Authorization  | Oncology          | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9348 | DANYELZA        | naxitamab-gqgk                                 | 1/1/2022   | Oncology          | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

| Code | Medical Specialty Drugs | Effective Date | Clinical Category | Note |
|------|-------------------------|----------------|-------------------|------|
|------|-------------------------|----------------|-------------------|------|

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|       |           |                           |  |          |  |
|-------|-----------|---------------------------|--|----------|--|
| J9349 | Monjuvi   | tafasitamab-cxix          | 1/1/2023   | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9350 | Lunsumio  | mosunetuzumab-axgb        | Covered effective 1/1/2024 with Prior Authorization  | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9352 | YONDELIS  | Trabectedin               | Precertification Notification 1/1/21-8/31/2024, Then covered 9/1/2024 with Prior Authorization | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9354 | Kadcyla   | ado-trastuzumab emtansine | 1/1/2023   | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9355 | HERCEPTIN | trastuzumab               | 8/1/2022   | Oncology | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

| Code | Medical Specialty Drugs | Effective Date | Clinical Category | Note |
|------|-------------------------|----------------|-------------------|------|
|------|-------------------------|----------------|-------------------|------|

To see a product list of physician-administered specialty medications or infusion therapies along with coverage and notification information please visit the

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|       |                   |                                     |  |             |  |
|-------|-------------------|-------------------------------------|--|-------------|--|
| J9356 | HERCEPTIN HYLECTA | trastuzumab /<br>hyaluronidase-oysk | 8/1/2022   | Oncology    | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9357 | VALSTAR           | Valrubicin                          | Precertification Notification 1/1/21-8/31/2024, Then covered 9/1/2024 with Prior Authorization | Oncology    | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9358 | Enhertu           | fam-trastuzumab<br>deruxtecan-nxki  | 1/1/2023   | Oncology    | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9359 | Zynlonta          | loncastuximab tesirine-<br>lpyl     | Covered effective 11/1/2024 with Prior Authorization   | Oncology    | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9361 | Ryzneuta          | efbemalenograstim<br>alfa-vuxw      | Covered effective 11/1/2024 with Prior Authorization   | Neutropenia | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

| Code | Medical Specialty Drugs | Effective Date | Clinical Category | Note |
|------|-------------------------|----------------|-------------------|------|
|------|-------------------------|----------------|-------------------|------|

To see a product list of physician-administered specialty medications or infusion therapies along with coverage and notification information please visit the

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|       |          |                    |   |                   |  |
|-------|----------|--------------------|---|-------------------|--|
| J9380 | Tecvayli | teclistamab cqyv   | Covered effective 1/1/2024 with Prior Authorization | Oncology          | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| J9382 | Bizengri | zenocutuzumab-zbco | Not covered until 11/1/25 with prior authorization  | Oncology          | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| Q4081 | EPOGEN   | epoetin alfa       | 8/1/2022  | Anemia (Dialysis) | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |
| Q4081 | PROCRIT  | epoetin alfa       | 8/1/2022  | Anemia (Dialysis) | <a href="#">Requires Prior Authorization Form be faxed to 512-831-5499</a> |

| CPT, HCPCS<br>or Revenue Code | Category III Description  | Comments/ Limitations |
|-------------------------------|---|-----------------------|
| 0071T                         | Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume less than 200 cc of tissue  |                       |
| 0072T                         | Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume greater or equal to 200 cc of tissue  |                       |
| 0100T                         | Placement of a subconjunctival retinal prosthesis receiver and pulse generator, and implantation of intraocular retinal electrode array, with vitrectomy  |                       |
| 0101T                         | Extracorporeal shock wave involving musculoskeletal system, not otherwise specified   |                       |
| 0102T                         | Extracorporeal shock wave performed by a physician, requiring anesthesia other than local, and involving the lateral humeral epicondyle   |                       |
| 0164T                         | Removal of total disc arthroplasty, (artificial disc), anterior approach, each additional interspace, lumbar  |                       |
| 0165T                         | Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, lumbar  |                       |
| 0200T                         | Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device, when used, 1 or more needles, includes imaging guidance and bone biopsy, when performed |                       |

| CPT, HCPCS<br>or Revenue Code | Category III Description   | Comments/ Limitations |
|-------------------------------|--|-----------------------|
| 0201T                         | Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device, when used, 2 or more needles, includes imaging guidance and bone biopsy, when performed |                       |
| 0214T                         | Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; second level                           |                       |
| 0216T                         | Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; single level                               |                       |
| 0218T                         | Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; third and any additional level(s)          |                       |
| 0221T                         | Placement of posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; lumbar   |                       |
| 0222T                         | Placement of posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; each additional vertebral segment                    |                       |
| 0232T                         | Injection(s), platelet rich plasma, any site, including image guidance, harvesting and preparation when performed  |                       |
| 0253T                         | Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the suprachoroidal space   |                       |

| CPT, HCPCS<br>or Revenue Code | Category III Description   | Comments/ Limitations |
|-------------------------------|--|-----------------------|
| 0263T                         | Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure including unilateral or bilateral bone marrow harvest  |                       |
| 0264T                         | Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure excluding bone marrow harvest  |                       |
| 0265T                         | Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; unilateral or bilateral bone marrow harvest only for intramuscular autologous bone marrow cell therapy  |                       |
| 0274T                         | Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (eg, fluoroscopic, CT), single or multiple levels, unilateral or bilateral; cervical or thoracic |                       |
| 0275T                         | Percutaneous laminotomy/laminectomy  |                       |
| 0278T                         | Transcutaneous electrical modulation pain reprocessing (e.g., scrambler therapy), each treatment session (includes placement of electrodes)  |                       |
| 0332T                         | Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment; with tomographic SPECT   |                       |
| 0335T                         | Extra-osseous subtalar joint implant   |                       |

| CPT, HCPCS<br>or Revenue Code | Category III Description   | Comments/ Limitations  |
|-------------------------------|--|--|
| 0348T                         | Radiologic examination, radiostereometric analysis (RSA); spine, (includes, cervical, thoracic and lumbosacral, when performed)  |  |
| 0349T                         | Radiologic examination, radiostereometric analysis (RSA); upper extremity(ies), (includes shoulder, elbow and wrist, when performed)   |  |
| 0350T                         | Radiologic examination, radiostereometric analysis (RSA); lower extremity(ies), (includes hip, proximal femur, knee and ankle, when performed)   |  |
| 0373T                         | Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components:  | <a href="#">Effective 1/1/24. Please use ABA form from the Prior Authorization Page of the mysmarthealth.org website for this request.</a> |
| 0378T                         | Visual field assessment, with concurrent real time data analysis and accessible data storage with patient initiated data transmitted to a remote surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified healthcare professional  |  |
| 0379T                         | Visual field assessment, with concurrent real time data analysis and accessible data storage with patient initiated data transmitted to a remote surveillance center for up to 30 days; technical support and patient instructions, surveillance, analysis, and transmission of daily and emergent data reports as prescribed by a physician or other qualified healthcare |  |
| 0402T                         | Collagen cross-linking of cornea (including removal of the corneal epithelium and intraoperative pachymetry when performed)  |  |
| 0408T                         | Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator with transvenous electrodes   |  |

| CPT, HCPCS<br>or Revenue Code | Category III Description  | Comments/ Limitations |
|-------------------------------|---|-----------------------|
| 0409T                         | Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator only       |                       |
| 0410T                         | Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator only       |                       |
| 0411T                         | Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; ventricular electrode only |                       |
| 0412T                         | Removal of permanent cardiac contractility modulation system; pulse generator only  |                       |
| 0413T                         | Removal of permanent cardiac contractility modulation system; transvenous electrode (atrial or ventricular)   |                       |
| 0414T                         | Removal and replacement of permanent cardiac contractility modulation system pulse generator only   |                       |
| 0415T                         | Repositioning of previously implanted cardiac contractility modulation transvenous electrode, (atrial or ventricular lead)  |                       |
| 0416T                         | Relocation of skin pocket for implanted cardiac contractility modulation pulse generator  |                       |

| CPT, HCPCS<br>or Revenue Code | Category III Description  | Comments/ Limitations |
|-------------------------------|---|-----------------------|
| 0417T                         | Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, including review and report, implantable cardiac contractility modulation system   |                       |
| 0418T                         | Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter; implantable cardiac contractility modulation system   |                       |
| 0448T                         | Removal of implantable interstitial glucose sensor with creation of subcutaneous pocket at different anatomic site and insertion of new implantable sensor, including system activation   |                       |
| 0449T                         | Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; initial device  |                       |
| 0481T                         | Injection(s), autologous white blood cell concentrate (autologous protein solution), any site, including image guidance, harvesting and preparation, when performed   |                       |
| 0483T                         | Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; percutaneous approach, including transseptal puncture, when performed   |                       |
| 0484T                         | Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; transthoracic exposure (eg, thoracotomy, transapical)   |                       |
| 0489T                         | Autologous adipose-derived regenerative cell therapy for scleroderma in the hands; adipose tissue harvesting, isolation and preparation of harvested cells including incubation with cell dissociation enzymes, removal of non-viable cells and debris, determination of concentration and dilution of regenerative cells |                       |

| CPT, HCPCS<br>or Revenue Code | Category III Description   | Comments/ Limitations |
|-------------------------------|--|-----------------------|
| 0490T                         | Autologous adipose-derived regenerative cell therapy for scleroderma in the hands;multiple injections in one or both hands   |                       |
| 0494T                         | Surgical preparation and cannulation of marginal (extended) cadaver donor lung(s) to ex vivo organ perfusion system, including decannulation, separation from the perfusion system, and cold preservation of the allograft prior to implantation, when performed   |                       |
| 0495T                         | Initiation and monitoring marginal (extended) cadaver donor lung(s) organ perfusion system by physician or qualified healthcare professional, including physiological and LABORatory assessment (eg, pulmonary artery flow, pulmonary artery pressure, left atrial pressure, pulmonary vascular resistance, mean/peak and plateau airway pressure, dynamic |                       |
| 0496T                         | each additional hour (List separately in addition to code for primary procedure)   |                       |
| 0505T                         | Endovenous femoral-popliteal arterial revascularization, with transcatheter placement of intravascular stent graft(s) and closure by any method,   |                       |
| 0510T                         | Removal of sinus tarsi implant   |                       |
| 0511T                         | Removal and reinsertion of sinus tarsi implant   |                       |
| 0512T                         | Extracorporeal shock wave for integumentary wound healing, including topical application and dressing care; initial wound  |                       |

| CPT, HCPCS<br>or Revenue Code | Category III Description   | Comments/ Limitations |
|-------------------------------|--|-----------------------|
| 0515T                         | Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; complete system (includes electrode and generator [transmitter and battery]) |                       |
| 0516T                         | Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; pulse generator component(s) (battery and/or transmitter) only               |                       |
| 0517T                         | Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; both components of pulse generator (battery and transmitter) only            |                       |
| 0518T                         | Removal of pulse generator for wireless cardiac stimulator for left ventricular pacing; battery component only   |                       |
| 0519T                         | Removal and replacement of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; both components (battery and transmitter)  |                       |
| 0520T                         | Removal and replacement of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; battery component only   |                       |
| 0521T                         | Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording, and disconnection per patient encounter, wireless cardiac stimulator for left ventricular pacing   |                       |
| 0522T                         | Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, including review and report, wireless cardiac                   |                       |

| CPT, HCPCS<br>or Revenue Code | Category III Description  | Comments/ Limitations |
|-------------------------------|---|-----------------------|
| 0524T                         | Endovenous catheter directed chemical ablation with balloon isolation of incompetent extremity vein, open or percutaneous, including all vascular access, catheter manipulation, diagnostic imaging, imaging guidance and monitoring        |                       |
| 0525T                         | Insertion or replacement of intracardiac ischemia monitoring system, including testing of the lead and monitor, initial system programming, and imaging supervision and interpretation; complete system (electrode and implantable monitor) |                       |
| 0526T                         | electrode only  |                       |
| 0527T                         | implantable monitor only  |                       |
| 0528T                         | Programming device evaluation (in person) of intracardiac ischemia monitoring system with iterative adjustment of programmed values, with analysis, review, and report  |                       |
| 0529T                         | Interrogation device evaluation (in person) of intracardiac ischemia monitoring system with analysis, review, and report  |                       |
| 0530T                         | Removal of intracardiac ischemia monitoring system, including all imaging supervision and interpretation; complete system (electrode and implantable monitor)   |                       |
| 0531T                         | electrode only  |                       |

| CPT, HCPCS<br>or Revenue Code | Category III Description   | Comments/ Limitations |
|-------------------------------|--|-----------------------|
| 0532T                         | implantable monitor only   |                       |
| 0544T                         | Transcatheter mitral valve annulus reconstruction, with implantation of adjustable annulus reconstruction device, percutaneous approach including transseptal puncture |                       |
| 0545T                         | Transcatheter tricuspid valve annulus reconstruction with implantation of adjustable annulus reconstruction device, percutaneous approach                              |                       |
| 0546T                         | Radiofrequency spectroscopy, real time, intraoperative margin assessment, at the time of partial mastectomy, with report   |                       |
| 0547T                         | Bone material quality testing by microindentation(s) of the tibia(s), with results reported as a score   |                       |
| 0552T                         | Low-level laser therapy, dynamic photonic and dynamic thermokinetic energies, provided by a physician or other qualified healthcare professional                       |                       |
| 0563T                         | Evacuation of meibomian glands, using heat delivered through wearable, open-eye eyelid treatment devices and manual gland expression, bilateral                        |                       |
| 0565T                         | Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; tissue harvesting and cellular implant creation              |                       |

| CPT, HCPCS<br>or Revenue Code | Category III Description  | Comments/ Limitations |
|-------------------------------|---|-----------------------|
| 0566T                         | Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; injection of cellular implant into knee joint including ultrasound guidance, unilateral   |                       |
| 0569T                         | Transcatheter tricuspid valve repair, percutaneous approach; initial prosthesis   |                       |
| 0581T                         | Ablation, malignant breast tumor(s), percutaneous, cryotherapy, including imaging guidance when performed, unilateral   |                       |
| 0584T                         | Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including guidance, and radiological supervision and interpretation, when performed; percutaneous  |                       |
| 0585T                         | Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including guidance, and radiological supervision and interpretation, when performed; laparoscopic  |                       |
| 0586T                         | Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including guidance, and radiological supervision and interpretation, when performed; open  |                       |
| 0587T                         | Percutaneous implantation or replacement of integrated single device neurostimulation system for bladder dysfunction including electrode array and receiver or pulse generator, including analysis, programming, and imaging guidance when performed, posterior tibial nerve  |                       |
| 0588T                         | Revision or removal of percutaneously placed integrated single device neurostimulation system for bladder dysfunction including electrode array and receiver or pulse generator, including analysis, programming, and imaging guidance when performed, posterior tibial nerve |                       |

| CPT, HCPCS<br>or Revenue Code | Category III Description   | Comments/ Limitations |
|-------------------------------|--|-----------------------|
| 0589T                         | Electronic analysis with simple programming of implanted integrated neurostimulation system for bladder dysfunction (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop               |                       |
| 0590T                         | Electronic analysis with complex programming of implanted integrated neurostimulation system for bladder dysfunction (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop              |                       |
| 0596T                         | Temporary female intraurethral valve-pump (ie, voiding prosthesis); initial insertion, including urethral measurement  |                       |
| 0597T                         | Temporary female intraurethral valve-pump (ie, voiding prosthesis); replacement  |                       |
| 0601T                         | Ablation, irreversible electroporation; 1 or more tumors per organ, including fluoroscopic and ultrasound guidance, when performed, open   |                       |
| 0607T                         | Remote monitoring of an external continuous pulmonary fluid monitoring system, including measurement of radiofrequency-derived pulmonary fluid levels, heart rate, respiration rate, activity, posture, and cardiovascular rhythm (eg, ECG data), transmitted to a remote 24-hour attended surveillance center; set-up and patient education on use of equipment             |                       |
| 0608T                         | Remote monitoring of an external continuous pulmonary fluid monitoring system, including measurement of radiofrequency-derived pulmonary fluid levels, heart rate, respiration rate, activity, posture, and cardiovascular rhythm (eg, ECG data), transmitted to a remote 24-hour attended surveillance center; analysis of data received and transmission of reports to the |                       |
| 0615T                         | Automated analysis of binocular eye movements without spatial calibration, including disconjugacy, saccades, and pupillary dynamics for the assessment of concussion, with interpretation and report   |                       |

| CPT, HCPCS<br>or Revenue Code | Category III Description  | Comments/ Limitations |
|-------------------------------|---|-----------------------|
| 0620T                         | Endovascular venous arterialization, tibial or peroneal vein, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the |                       |
| 0627T                         | Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; first level  |                       |
| 0629T                         | Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; first level  |                       |
| 0633T                         | Computed tomography, breast, including 3D rendering, when performed, unilateral; without contrast material  |                       |
| 0634T                         | Computed tomography, breast, including 3D rendering, when performed, unilateral; with contrast material(s)  |                       |
| 0635T                         | Computed tomography, breast, including 3D rendering, when performed, unilateral; without contrast, followed by contrast material(s)   |                       |
| 0636T                         | Computed tomography, breast, including 3D rendering, when performed, bilateral; without contrast material(s)  |                       |
| 0637T                         | Computed tomography, breast, including 3D rendering, when performed, bilateral; with contrast material(s)   |                       |

| CPT, HCPCS<br>or Revenue Code | Category III Description  | Comments/ Limitations |
|-------------------------------|---|-----------------------|
| 0638T                         | Computed tomography, breast, including 3D rendering, when performed, bilateral; without contrast, followed by contrast material(s)  |                       |
| 0646T                         | Transcatheter tricuspid valve implantation/replacement (TTVI) with prosthetic valve, percutaneous approach, including right heart catheterization, temporary pacemaker insertion, and selective right ventricular or right atrial angiography, when performed   | Effective 7/1/21      |
| 0648T                         | Quantitative magnetic resonance for analysis of tissue composition (eg, fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained without diagnostic MRI examination of the same anatomy (eg, organ, gland, tissue, target structure) during the same session; single | Effective 7/1/21      |
| 0652T                         | Esophagogastroduodenoscopy, flexible, transnasal; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)   | Effective 7/1/21      |
| 0653T                         | Esophagogastroduodenoscopy, flexible, transnasal; with biopsy, single or multiple   | Effective 7/1/21      |
| 0654T                         | Esophagogastroduodenoscopy, flexible, transnasal; with insertion of intraluminal tube or catheter   | Effective 7/1/21      |
| 0655T                         | Transperineal focal laser ablation of malignant prostate tissue, including transrectal imaging guidance, with MR-fused images or other enhanced ultrasound imaging  | Effective 7/1/21      |
| 0656T                         | Anterior lumbar or thoracolumbar vertebral body tethering; up to 7 vertebral segments   | Effective 7/1/21      |

| CPT, HCPCS<br>or Revenue Code | Category III Description   | Comments/ Limitations |
|-------------------------------|--|-----------------------|
| 0657T                         | Anterior lumbar or thoracolumbar vertebral body tethering; 8 or more vertebral segments  | Effective 7/1/21      |
| 0658T                         | Electrical impedance spectroscopy of 1 or more skin lesions for automated melanoma risk score  | Effective 7/1/21      |
| 0659T                         | Transcatheter intracoronary infusion of supersaturated oxygen in conjunction with percutaneous coronary revascularization during acute myocardial infarction, including catheter placement, imaging guidance (eg, fluoroscopy), angiography, and radiologic supervision and interpretation | Effective 7/1/21      |
| 0664T                         | Donor hysterectomy (including cold preservation); open, from cadaver donor   | Effective 7/1/21      |
| 0665T                         | Donor hysterectomy (including cold preservation); open, from living donor  | Effective 7/1/21      |
| 0666T                         | Donor hysterectomy (including cold preservation); laparoscopic or robotic, from living donor   | Effective 7/1/21      |
| 0667T                         | Donor hysterectomy (including cold preservation); recipient uterus allograft transplantation from cadaver or living donor  | Effective 7/1/21      |
| 0668T                         | Backbench standard preparation of cadaver or living donor uterine allograft prior to transplantation, including dissection and removal of surrounding soft tissues and preparation of uterine vein(s) and uterine artery(ies), as necessary  | Effective 7/1/21      |

| CPT, HCPCS<br>or Revenue Code | Category III Description  | Comments/ Limitations |
|-------------------------------|---|-----------------------|
| 0669T                         | Backbench reconstruction of cadaver or living donor uterus allograft prior to transplantation; venous anastomosis, each   | Effective 7/1/21      |
| 0670T                         | Backbench reconstruction of cadaver or living donor uterus allograft prior to transplantation; arterial anastomosis, each   | Effective 7/1/21      |
| 0671T                         | Insertion of anterior segment aqueous drainage device into the trabecular meshwork, without external reservoir, and without concomitant cataract removal, one or more   | Effective 1/1/2022    |
| 0673T                         | Ablation, benign thyroid nodule(s), percutaneous, laser, including imaging guidance   | Effective 1/1/2022    |
| 0686T                         | Histotripsy (ie, non-thermal ablation via acoustic energy delivery) of malignant hepatocellular tissue, including image guidance  | Effective 1/1/2022    |
| 0687T                         | Treatment of amblyopia using an online digital program; device supply, educational set-up, and initial session  | Effective 1/1/2022    |
| 0688T                         | Treatment of amblyopia using an online digital program; assessment of patient performance and program data by physician or other qualified healthcare professional, with report, per calendar month                           | Effective 1/1/2022    |
| 0689T                         | Quantitative ultrasound tissue characterization (non-elastographic), including interpretation and report, obtained without diagnostic ultrasound examination of the same anatomy (eg, organ, gland, tissue, target structure) | Effective 1/1/2022    |

| CPT, HCPCS<br>or Revenue Code | Category III Description   | Comments/ Limitations |
|-------------------------------|--|-----------------------|
| 0690T                         | Quantitative ultrasound tissue characterization (non-elastographic), including interpretation and report, obtained with diagnostic ultrasound examination of the same anatomy (eg, organ, gland, tissue, target structure) (List separately in addition to code for primary procedure) | Effective 1/1/2022    |
| 0692T                         | Therapeutic ultrafiltration  | Effective 1/1/2022    |
| 0700T                         | Molecular fluorescent imaging of suspicious nevus; first lesion  | Effective 1/1/2022    |
| 0701T                         | Molecular fluorescent imaging of suspicious nevus; each additional lesion (List separately in addition to code for primary procedure)  | Effective 1/1/2022    |
| 0704T                         | Remote treatment of amblyopia using an eye tracking device; device supply with initial set-up and patient education on use of equipment  | Effective 1/1/2022    |
| 0705T                         | Remote treatment of amblyopia using an eye tracking device; surveillance center technical support including data transmission with analysis, with a minimum of 18 training hours, each 30 days   | Effective 1/1/2022    |
| 0706T                         | Remote treatment of amblyopia using an eye tracking device; interpretation and report by physician or other qualified healthcare professional, per calendar month  | Effective 1/1/2022    |
| 0707T                         | Injection(s), bone-substitute material (eg, calcium phosphate) into subchondral bone defect (ie, bone marrow lesion, bone bruise, stress injury, microtrabecular fracture), including imaging guidance and arthroscopic assistance for joint visualization                             | Effective 1/1/2022    |

| CPT, HCPCS<br>or Revenue Code | Category III Description   | Comments/ Limitations |
|-------------------------------|--|-----------------------|
| 0717T                         | Autologous Adipose-Derived Regenerative Cell (Adrc) Therapy For Partial Thickness Rotator Cuff Tear; Adipose Tissue Harvesting, Isolation And Preparation Of Harvested Cells, Including Incubation With Cell Dissociation Enzymes, Filtration, Washing And Concentration Of Adrcs                                  | Effective 7/1/2022    |
| 0718T                         | Autologous Adipose-Derived Regenerative Cell (Adrc) Therapy For Partial Thickness Rotator Cuff Tear; Injection Into Supraspinatus Tendon Including Ultrasound Guidance, Unilateral   | Effective 7/1/2022    |
| 0736T                         | Colonic Lavage, 35 Or More Liters Of Water, Gravity-Fed, With Induced Defecation, Including Insertion Of Rectal Catheter   | Effective 7/1/2022    |
| 0738T                         | Treatment planning for magnetic field induction ablation of malignant prostate tissue, using data from previously performed magnetic resonance imaging (MRI) examination   | Effective 1/1/2023    |
| 0739T                         | Ablation of malignant prostate tissue by magnetic field induction, including all intraprocedural, transperineal needle/catheter placement for nanoparticle installation and intraprocedural temperature monitoring, thermal dosimetry, bladder irrigation, and magnetic field nanoparticle activation              | Effective 1/1/2023    |
| 0742T                         | Absolute quantitation of myocardial blood flow (AQMBF), single-photon emission computed tomography (SPECT), with exercise or pharmacologic stress, and at rest, when performed (List separately in addition to code for primary procedure)   | Effective 1/1/2023    |
| 0745T                         | Cardiac focal ablation utilizing radiation therapy for arrhythmia; noninvasive arrhythmia localization and mapping of arrhythmia site (nidus), derived from anatomical image data (eg, CT, MRI, or myocardial perfusion scan) and electrical data (eg, 12-lead ECG data), and identification of areas of avoidance | Effective 1/1/2023    |
| 0746T                         | Cardiac focal ablation utilizing radiation therapy for arrhythmia; conversion of arrhythmia localization and mapping of arrhythmia site (nidus) into a multidimensional radiation treatment plan   | Effective 1/1/2023    |

| CPT, HCPCS<br>or Revenue Code | Category III Description  | Comments/ Limitations |
|-------------------------------|---|-----------------------|
| 0747T                         | Cardiac focal ablation utilizing radiation therapy for arrhythmia; delivery of radiation therapy, arrhythmia  | Effective 1/1/2023    |
| 0766T                         | Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, with identification and marking of the treatment location, including noninvasive electroneurographic localization (nerve conduction localization), when performed; first nerve  | Effective 1/1/2023    |
| 0770T                         | Virtual reality technology to assist therapy (List separately in addition to code for primary procedure)  | Effective 1/1/2023    |
| 0771T                         | Virtual reality (VR) procedural dissociation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports, requiring the presence of an independent, trained observer to assist in the monitoring of the patient's level of dissociation or                    | Effective 1/1/2023    |
| 0772T                         | Virtual reality (VR) procedural dissociation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports, requiring the presence of an independent, trained observer to assist in the monitoring of the patient's level of dissociation or                    | Effective 1/1/2023    |
| 0773T                         | Virtual reality (VR) procedural dissociation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports; initial 15 minutes of intraservice time, patient age 5 years or older                 | Effective 1/1/2023    |
| 0774T                         | Virtual reality (VR) procedural dissociation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports; each additional 15 minutes intraservice time (List separately in addition to code for | Effective 1/1/2023    |
| 0778T                         | Surface mechanomyography (sMMG) with concurrent application of inertial measurement unit (IMU) sensors for measurement of multi-joint range of motion, posture, gait, and muscle function   | Effective 1/1/2023    |

| CPT, HCPCS<br>or Revenue Code | Category III Description  | Comments/ Limitations |
|-------------------------------|---|-----------------------|
| 0783T                         | Transcutaneous auricular neurostimulation, set-up, calibration, and patient education on use of equipment   | Effective 1/1/2023    |
| 0786T                         | Insertion or replacement of percutaneous electrode array, sacral, with integrated neurostimulator, including imaging guidance, when performed   | Effective 1/1/24      |
| 0787T                         | Revision or removal of neurostimulator electrode array, sacral, with integrated neurostimulator   | Effective 1/1/24      |
| 0790T                         | Revision (eg, augmentation, division of tether), replacement, or removal of thoracolumbar or lumbar vertebral body tethering, including thoracoscopy, when performed  | Effective 1/1/24      |
| 0795T                         | Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; complete system (ie, right atrial and right ventricular     | Effective 10/1/2023   |
| 0796T                         | Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; right atrial pacemaker component (when an existing right    | Effective 10/1/2023   |
| 0797T                         | Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; right ventricular pacemaker component (when part of a dual- | Effective 10/1/2023   |
| 0798T                         | Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; complete system (ie, right atrial and right ventricular pacemaker components)  | Effective 10/1/2023   |

| CPT, HCPCS<br>or Revenue Code | Category III Description  | Comments/ Limitations |
|-------------------------------|---|-----------------------|
| 0799T                         | Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; right atrial pacemaker component   | Effective 10/1/2023   |
| 0800T                         | Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)  | Effective 10/1/2023   |
| 0801T                         | Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; dual-chamber system (ie, right atrial and right ventricular | Effective 10/1/2023   |
| 0802T                         | Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; right atrial pacemaker component                            | Effective 10/1/2023   |
| 0803T                         | Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; right ventricular pacemaker component (when part of a dual- | Effective 10/1/2023   |
| 0804T                         | Programming device evaluation (in person) with iterative adjustment of implantable device to test the function of device and to select optimal permanent programmed values, with analysis, review, and report, by a physician or other qualified health care professional, leadless pacemaker system in dual cardiac chambers                                   | Effective 10/1/2023   |
| 0810T                         | Subretinal injection of a pharmacologic agent, including vitrectomy and 1 or more retinotomies  | Effective 10/1/2023   |
| 0813T                         | Esophagogastroduodenoscopy, flexible, transoral, with volume adjustment of intragastric bariatric balloon   | Effective 1/1/24      |

| CPT, HCPCS<br>or Revenue Code | Category III Description   | Comments/ Limitations |
|-------------------------------|--|-----------------------|
| 0816T                         | Open insertion or replacement of integrated neurostimulation system for bladder dysfunction including electrode(s) (eg, array or leadless), and pulse generator or receiver, including analysis, programming, and imaging guidance, when performed, posterior tibial nerve; subcutaneous   | Effective 1/1/24      |
| 0817T                         | Open insertion or replacement of integrated neurostimulation system for bladder dysfunction including electrode(s) (eg, array or leadless), and pulse generator or receiver, including analysis, programming, and imaging guidance, when performed, posterior tibial nerve; subfascial   | Effective 1/1/24      |
| 0818T                         | Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming, and imaging, when performed, posterior tibial nerve; subcutaneous  | Effective 1/1/24      |
| 0819T                         | Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming, and imaging, when performed, posterior tibial nerve; subfascial  | Effective 1/1/24      |
| 0823T                         | Transcatheter insertion of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography) and device evaluation (eg, interrogation or programming), when performed               | Effective 1/1/24      |
| 0824T                         | Transcatheter removal of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography), when performed  | Effective 1/1/24      |
| 0825T                         | Transcatheter removal and replacement of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography) and device evaluation (eg, interrogation or programming), when performed | Effective 1/1/24      |
| 0861T                         | Removal of pulse generator for wireless cardiac stimulator for left ventricular pacing; both components (battery and transmitter)  | Effective 1/1/24      |

| CPT, HCPCS<br>or Revenue Code | Category III Description  | Comments/ Limitations |
|-------------------------------|---|-----------------------|
| 0862T                         | Relocation of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; battery component only   | Effective 1/1/24      |
| 0863T                         | Relocation of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; transmitter component only   | Effective 1/1/24      |
| 0864T                         | Low-intensity extracorporeal shock wave therapy involving corpus cavernosum, low energy   | Effective 1/1/24      |
| 0894T                         | Cannulation of the liver allograft in preparation for connection to the normothermic perfusion device and decannulation of the liver allograft following normothermic perfusion   | Effective 7/1/2024    |
| 0895T                         | Connection of liver allograft to normothermic machine perfusion device, hemostasis control; initial 4 hours of monitoring time, including hourly physiological and laboratory assessments (eg, perfusate temperature, perfusate pH, hemodynamic parameters, bile production, bile pH, bile glucose, biliary bicarbonate, lactate levels, macroscopic                | Effective 7/1/2024    |
| 0899T                         | Noninvasive determination of absolute quantitation of myocardial blood flow (AQMBF), derived from augmentative algorithmic analysis of the dataset acquired via contrast cardiac magnetic resonance (CMR), pharmacologic stress, with interpretation and report by a physician or other qualified health care professional (List separately in addition to code for | Effective 7/1/2024    |
| 0900T                         | Noninvasive estimate of absolute quantitation of myocardial blood flow (AQMBF), derived from assistive algorithmic analysis of the dataset acquired via contrast cardiac magnetic resonance (CMR), pharmacologic stress, with interpretation and report by a physician or other qualified health care professional (List separately in addition to code for primary | Effective 7/1/2024    |
| 0915T                         | Insertion of permanent cardiac contractility modulation-defibrillation system component(s), including fluoroscopic guidance, and evaluation and programming of sensing and therapeutic parameters; pulse generator and dual transvenous electrodes/leads (pacing and defibrillation)  | Effective 1/1/2025    |

| CPT, HCPCS<br>or Revenue Code | Category III Description   | Comments/ Limitations |
|-------------------------------|--|-----------------------|
| 0916T                         | Insertion of permanent cardiac contractility modulation-defibrillation system component(s), including fluoroscopic guidance, and evaluation and programming of sensing and therapeutic parameters; pulse generator only                                    | Effective 1/1/2025    |
| 0917T                         | Insertion of permanent cardiac contractility modulation-defibrillation system component(s), including fluoroscopic guidance, and evaluation and programming of sensing and therapeutic parameters; single transvenous lead (pacing or defibrillation) only | Effective 1/1/2025    |
| 0918T                         | Insertion of permanent cardiac contractility modulation-defibrillation system component(s), including fluoroscopic guidance, and evaluation and programming of sensing and therapeutic parameters; dual transvenous leads (pacing and defibrillation) only | Effective 1/1/2025    |
| 0919T                         | Removal of a permanent cardiac contractility modulation-defibrillation system component(s); pulse generator only   | Effective 1/1/2025    |
| 0920T                         | Removal of a permanent cardiac contractility modulation-defibrillation system component(s); single transvenous pacing lead only  | Effective 1/1/2025    |
| 0921T                         | Removal of a permanent cardiac contractility modulation-defibrillation system component(s); single transvenous defibrillation lead only  | Effective 1/1/2025    |
| 0922T                         | Removal of a permanent cardiac contractility modulation-defibrillation system component(s); dual (pacing and defibrillation) transvenous leads only  | Effective 1/1/2025    |
| 0923T                         | Removal and replacement of permanent cardiac contractility modulation-defibrillation pulse generator only  | Effective 1/1/2025    |

| CPT, HCPCS<br>or Revenue Code | Category III Description   | Comments/ Limitations |
|-------------------------------|--|-----------------------|
| 0924T                         | Repositioning of previously implanted cardiac contractility modulation-defibrillation transvenous electrode(s)/lead(s), including fluoroscopic guidance and programming of sensing and therapeutic parameters  | Effective 1/1/2025    |
| 0925T                         | Relocation of skin pocket for implanted cardiac contractility modulation-defibrillation pulse generator  | Effective 1/1/2025    |
| 0926T                         | Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, including review and report, implantable cardiac contractility modulation-defibrillation system   | Effective 1/1/2025    |
| 0927T                         | Interrogation device evaluation (in person) with analysis, review, and report, including connection, recording, and disconnection, per patient encounter, implantable cardiac contractility modulation-defibrillation system   | Effective 1/1/2025    |
| 0928T                         | Interrogation device evaluation (remote), up to 90 days, cardiac contractility modulation-defibrillation system with interim analysis and report(s) by a physician or other qualified health care professional   | Effective 1/1/2025    |
| 0929T                         | Interrogation device evaluation (remote), up to 90 days, cardiac contractility modulation-defibrillation system, remote data acquisition(s), receipt of transmissions, technician review, technical support, and distribution of results   | Effective 1/1/2025    |
| 0930T                         | Electrophysiologic evaluation of cardiac contractility modulation-defibrillator leads, including defibrillation-threshold evaluation (induction of arrhythmia, evaluation of sensing and therapy for arrhythmia termination), at time of initial implantation or replacement with testing of cardiac contractility modulation-defibrillator pulse generator    | Effective 1/1/2025    |
| 0931T                         | Electrophysiologic evaluation of cardiac contractility modulation-defibrillator leads, including defibrillation-threshold evaluation (induction of arrhythmia, evaluation of sensing and therapy for arrhythmia termination), separate from initial implantation or replacement with testing of cardiac contractility modulation-defibrillator pulse generator | Effective 1/1/2025    |

| CPT, HCPCS<br>or Revenue Code | Category III Description  | Comments/ Limitations |
|-------------------------------|---|-----------------------|
| 0933T                         | Transcatheter implantation of wireless left atrial pressure sensor for long-term left atrial pressure monitoring, including sensor calibration and deployment, right heart catheterization, transseptal puncture, imaging guidance, and radiological supervision and interpretation   | Effective 1/1/2025    |
| 0934T                         | Remote monitoring of a wireless left atrial pressure sensor for up to 30 days, including data from daily uploads of left atrial pressure recordings, interpretation(s) and trend analysis, with adjustments to the diuretics plan, treatment paradigm thresholds, medications or lifestyle modifications, when performed, and report(s) by a physician or other qualified | Effective 1/1/2025    |
| 0935T                         | Cystourethroscopy with renal pelvic sympathetic denervation, radiofrequency ablation, retrograde ureteral approach, including insertion of guide wire, selective placement of ureteral sheath(s) and multiple conformable electrodes, contrast injection(s), and fluoroscopy, bilateral   | Effective 1/1/2025    |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description  | Comments/ Limitations |
|--|--|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |  |                       |
| 01999  | dental procedure   |                       |
| 11950  | Subcutaneous injection of filling material (eg, collagen); 1 cc or less  |                       |
| 11951  | 1.1 to 5.0 cc  |                       |
| 11952  | 5.1 to 10.0 cc   |                       |
| 11954  | over 10.0 cc   |                       |
| 15271  | Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area   |                       |
| 15273  | Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface  |                       |
| 15275  | Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area |                       |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description  | Comments/ Limitations  |
|---|--|------------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</p> |  |                        |
| 15277   | Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children |                        |
| 15771   | Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50cc or less injectate:   | Effective June 1, 2021 |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description  | Comments/ Limitations  |
|--|--|--|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |  |  |
| 15772  | autologous fat grafting to the trunk, breasts, extremities, or scalp for each additional 50cc of injectate | Prior Authorization is not required for the following Diagnosis Codes: C50.011,C50.012,C50.019,C50.021,C50.022,C50.029,C50.111,C50.112,C50.119,C50.121, C50.122, C50.129,C50.211,C50.212,C50.219,C50.221,C50.222, C50.229,C50.311,C50.312,C50.319,C50.321, C50.322,C50.329,C50.411 ,C50.412,C50.419,C50.421,C50.422, C50.429,C50.511,C50.512,C50.519, C50.521,C50.522,C50.529,C50.611,C50.612,C50.619,C50.621.C50.622,C50.629,C50.811,C50.812,C50.819,C50.821,C50.822,C50.829,C50.911 ,C50.912,C50.919,C50.921,C50.922,C50.929, C79.81,D05.00,D05.01, D05.02,D05.10,D05.11,D05.12, D05.80,D05.81,D05.82,D05.90,D05.91, D05.92,D48.61,D48.62, I97.2,N65.0, N65.1,Q79.8.T85.43XA,T85.43XD,T85.43XS,Z42.1,Z45.811,Z45.812,Z45.811, Z45.819,Z85.3,Z90.10,Z90.11,Z90.12, Z90.13 |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description  | Comments/ Limitations       |
|---|--|-----------------------------|
| <p style="color: red; text-align: center;">Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</p> |  |                             |
| 15773   | Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet | Effective September 1, 2021 |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description  | Comments/ Limitations   |
|--|--|---|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |  |   |
| 15777  | Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (eg, breast, trunk) (List separately in addition to code for primary procedure) | <p>Prior Authorization is not required for the following Diagnosis Codes: C50.011,C50.012,C50.019,C50.021,C50.022,C50.029,C50.111,C50.112,C50.119,C50.121, C50.122, C50.129,C50.211,C50.212,C50.219,C50.221,C50.222, C50.229,C50.311,C50.312,C50.319,C50.321, C50.322,C50.329,C50.411 ,C50.412,C50.419,C50.421,C50.422, C50.429,C50.511,C50.512,C50.519, C50.521,C50.522,C50.529,C50.611,C50.612,C50.619,C50.621.C50.622,C50.629,C50.811,C50.812,C50.819,C50.821,C50.822,C50.829,C50.911 ,C50.912,C50.919,C50.921,C50.922,C50.929, C79.81,D05.00,D05.01, D05.02,D05.10,D05.11,D05.12, D05.80,D05.81,D05.82,D05.90,D05.91, D05.92,D48.61,D48.62, I97.2,N65.0, N65.1,Q79.8.T85.43XA,T85.43XD,T85.43XS,Z42.1,Z45.811,Z45.812,Z45.811, Z45.819,Z85.3,Z90.10,Z90.11,Z90.12, Z90.13</p> |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description  | Comments/ Limitations |
|--|--|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |  |                       |
| 15780  | Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis) |                       |
| 15781  | segmental, face  |                       |
| 15782  | regional, other than face  |                       |
| 15786  | Abrasion (e.g. keratosis, scar) - single & multiple  |                       |
| 15787  | Abrasion (e.g. keratosis, scar) - single & multiple  |                       |
| 15792  | Chemical peel, non facial; epidermal   |                       |
| 15793  | dermal   |                       |
| 15822  | Blepharoplasty – upper eyelid  |                       |
| 15823  | Blepharoplasty – upper eyelid  |                       |
| 15824  | Rhytidectomy; forehead   |                       |
| 15825  | neck with platysmal tightening (platysmal flap, P-flap)                                      |                       |
| 15826  | gLABellar frown lines  |                       |
| 15828  | cheek, chin, and neck  |                       |
| 15829  | superficial musculoaponeurotic system (SMAS) flap  |                       |
| 15830  | Panniculectomy   |                       |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description  | Comments/ Limitations  |
|--|--|------------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |  |                        |
| 15832  | thigh  |                        |
| 15833  | leg  |                        |
| 15834  | hip  |                        |
| 15835  | buttock  |                        |
| 15836  | arm  |                        |
| 15837  | forearm or hand  |                        |
| 15838  | submental fat pad  |                        |
| 15839  | other area   |                        |
| 15840  | Graft for facial nerve paralysis; free fascia graft (including obtaining fascia) |                        |
| 15841  | free muscle graft (including obtaining graft)                                    |                        |
| 15842  | free muscle flap by microsurgical technique                                      |                        |
| 15845  | regional muscle transfer   |                        |
| 15847  | Abdominoplasty   |                        |
| 15877  | Lipectomy – suction assisted   |                        |
| 15879  | Lipectomy - lower extremity  | Effective June 1, 2021 |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description   | Comments/ Limitations |
|--|---|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |   |                       |
| 17106  | Destruction of cutaneous vascular proliferative lesions, less than 10 sq cm |                       |
| 17107  | Destruction of cutaneous vascular proliferative lesions, 10.0 to 50.0 sq cm |                       |
| 17108  | Destruction of cutaneous vascular proliferative lesions, over 50.0 sq cm    |                       |
| 17999  | Unlisted procedure – skin, mucous membrane & subcutaneous tissue            |                       |
| 19300  | Mastectomy for gynecomastia   |                       |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description        | Comments/ Limitations  |
|--|------------------------------|--|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |                              |  |
| 19303  | Mastectomy, simple, complete | Prior Authorization is not required for the following Diagnosis Codes: C50.011,C50.012,C50.019,C50.021,C50.022,C50.029,C50.111,C50.112,C50.119,C50.121, C50.122, C50.129,C50.211,C50.212,C50.219,C50.221,C50.222, C50.229,C50.311,C50.312,C50.319,C50.321, C50.322,C50.329,C50.411 ,C50.412,C50.419,C50.421,C50.422, C50.429,C50.511,C50.512,C50.519, C50.521,C50.522,C50.529,C50.611,C50.612,C50.619,C50.621.C50.622,C50.629,C50.811,C50.812,C50.819,C50.821,C50.822,C50.829,C50.911 ,C50.912,C50.919,C50.921,C50.922,C50.929, C79.81,D05.00,D05.01, D05.02,D05.10,D05.11,D05.12, D05.80,D05.81,D05.82,D05.90,D05.91, D05.92,D48.61,D48.62, I97.2,N65.0, N65.1,Q79.8.T85.43XA,T85.43XD,T85.43XS,Z42.1,Z45.811,Z45.812,Z45.811, Z45.819,Z85.3,Z90.10,Z90.11,Z90.12, Z90.13 |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description   | Comments/ Limitations   |
|--|---|---|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |   |   |
| 19305  | Mastectomy, radical, including pectoral muscles, axillary lymph nodes | <p>Prior Authorization is not required for the following Diagnosis Codes: C50.011,C50.012,C50.019,C50.021,C50.022,C50.029,C50.111,C50.112,C50.119,C50.121, C50.122, C50.129,C50.211,C50.212,C50.219,C50.221,C50.222, C50.229,C50.311,C50.312,C50.319,C50.321, C50.322,C50.329,C50.411 ,C50.412,C50.419,C50.421,C50.422, C50.429,C50.511,C50.512,C50.519, C50.521,C50.522,C50.529,C50.611,C50.612,C50.619,C50.621.C50.622,C50.629,C50.811,C50.812,C50.819,C50.821,C50.822,C50.829,C50.911 ,C50.912,C50.919,C50.921,C50.922,C50.929, C79.81,D05.00,D05.01, D05.02,D05.10,D05.11,D05.12, D05.80,D05.81,D05.82,D05.90,D05.91, D05.92,D48.61,D48.62, I97.2,N65.0, N65.1,Q79.8.T85.43XA,T85.43XD,T85.43XS,Z42.1,Z45.811,Z45.812,Z45.811, Z45.819,Z85.3,Z90.10,Z90.11,Z90.12, Z90.13</p> |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description   | Comments/ Limitations   |
|--|---|---|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |   |   |
| 19306  | Mastectomy, radical, including pectoral muscles, axillary and internal mammary lymph nodes (Urban type operation) | <p>Prior Authorization is not required for the following Diagnosis Codes: C50.011,C50.012,C50.019,C50.021,C50.022,C50.029,C50.111,C50.112,C50.119,C50.121, C50.122, C50.129,C50.211,C50.212,C50.219,C50.221,C50.222, C50.229,C50.311,C50.312,C50.319,C50.321, C50.322,C50.329,C50.411 ,C50.412,C50.419,C50.421,C50.422, C50.429,C50.511,C50.512,C50.519, C50.521,C50.522,C50.529,C50.611,C50.612,C50.619,C50.621.C50.622,C50.629,C50.811,C50.812,C50.819,C50.821,C50.822,C50.829,C50.911 ,C50.912,C50.919,C50.921,C50.922,C50.929, C79.81,D05.00,D05.01, D05.02,D05.10,D05.11,D05.12, D05.80,D05.81,D05.82,D05.90,D05.91, D05.92,D48.61,D48.62, I97.2,N65.0, N65.1,Q79.8.T85.43XA,T85.43XD,T85.43XS,Z42.1,Z45.811,Z45.812,Z45.811, Z45.819,Z85.3,Z90.10,Z90.11,Z90.12, Z90.13</p> |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description  | Comments/ Limitations   |
|--|--|---|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |  |   |
| 19307  | Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle | <p>Prior Authorization is not required for the following Diagnosis Codes: C50.011,C50.012,C50.019,C50.021,C50.022,C50.029,C50.111,C50.112,C50.119,C50.121, C50.122, C50.129,C50.211,C50.212,C50.219,C50.221,C50.222, C50.229,C50.311,C50.312,C50.319,C50.321, C50.322,C50.329,C50.411 ,C50.412,C50.419,C50.421,C50.422, C50.429,C50.511,C50.512,C50.519, C50.521,C50.522,C50.529,C50.611,C50.612,C50.619,C50.621.C50.622,C50.629,C50.811,C50.812,C50.819,C50.821,C50.822,C50.829,C50.911 ,C50.912,C50.919,C50.921,C50.922,C50.929, C79.81,D05.00,D05.01, D05.02,D05.10,D05.11,D05.12, D05.80,D05.81,D05.82,D05.90,D05.91, D05.92,D48.61,D48.62, I97.2,N65.0, N65.1,Q79.8.T85.43XA,T85.43XD,T85.43XS,Z42.1,Z45.811,Z45.812,Z45.811, Z45.819,Z85.3,Z90.10,Z90.11,Z90.12, Z90.13</p> |
| 19316  | Mastopexy  |   |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description  | Comments/ Limitations |
|--|--|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |  |                       |
| 19318  | Reduction mammoplasty  |                       |
| 19325  | Mammoplasty, augmentation w/ or w/o implant  |                       |
| 19328  | Removal of mammary implant material  |                       |
| 19330  | Removal of mammary implant material  |                       |
| 19340  | Immediate or delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction |                       |
| 19342  | Immediate or delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction |                       |
| 19350  | Nipple/areola reconstruction   |                       |
| 19355  | Correction of inverted nipples   |                       |
| 19357  | Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion        |                       |
| 19361  | Breast reconstruction with latissimus dorsi flap, without prosthetic implant                             |                       |
| 19364  | Breast reconstruction with free flap   |                       |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description   | Comments/ Limitations |
|---|---|-----------------------|
| <b>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</b> |   |                       |
| 19367   | Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site                          |                       |
| 19368   | with microvascular anastomosis (supercharging)  |                       |
| 19369   | Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site                          |                       |
| 19370   | Periprosthetic capsulectomy   |                       |
| 19371   | Periprosthetic capsulectomy   |                       |
| 19380   | Revision of reconstructed breast  |                       |
| 19396   | Moulage preparation for custom implant  |                       |
| 19499   | Unlisted procedure – breast   |                       |
| 20912   | Nasal cartilage graft   | Effective 1/1/2021    |
| 20932   | Allograft, includes templating, cutting, placement and internal fixation, when performed; osteoarticular, including articular surface and contiguous bone |                       |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description   | Comments/ Limitations |
|--|---|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |   |                       |
| 20933  | hemicortical intercalary, partial (ie, hemicylindrical) (List separately in addition to code for primary procedure) |                       |
| 20934  | intercalary, complete (ie, cylindrical) (List separately in addition to code for primary procedure)                 |                       |
| 21110  | Interdental fixation device for conditions other than fracture or dislocation                                       |                       |
| 21120  | Genioplasty; augmentation - all types   |                       |
| 21121  | sliding osteotomy, single piece   |                       |
| 21122  | Genioplasty; augmentation - all types   |                       |
| 21123  | Genioplasty; augmentation - all types   |                       |
| 21125  | Augmentation, mandibular angle; prosthetic material or bone graft   |                       |
| 21127  | Augmentation, mandibular angle; prosthetic material or bone graft   |                       |
| 21137  | Forehead reduction  |                       |
| 21138  | Forehead reduction  |                       |
| 21139  | Forehead reduction  |                       |
| 21141  | Midface reconstruction  |                       |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description                       | Comments/ Limitations |
|--|---|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |   |                       |
| 21142  | Midface reconstruction                      |                       |
| 21143  | Midface reconstruction                      |                       |
| 21145  | Midface reconstruction                      |                       |
| 21146  | Midface reconstruction                      |                       |
| 21147  | Midface reconstruction                      |                       |
| 21150  | Midface reconstruction                      |                       |
| 21151  | Midface reconstruction                      |                       |
| 21154  | Midface reconstruction                      |                       |
| 21155  | Midface reconstruction                      |                       |
| 21159  | Midface reconstruction                      |                       |
| 21160  | Midface reconstruction                      |                       |
| 21172  | Forehead reconstruction                     |                       |
| 21175  | Forehead reconstruction                     |                       |
| 21179  | Forehead reconstruction                     |                       |
| 21180  | Forehead reconstruction                     |                       |
| 21210  | Graft, bone, nasal,maxillary or malar areas | Effective 1/1/2021    |
| 21280  | Canthopexy                                  |                       |
| 21282  | Canthopexy                                  |                       |
| 22101  | thoracic                                    |                       |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description  | Comments/ Limitations |
|--|--|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |  |                       |
| 22102  | lumbar   |                       |
| 22103  | each additional segment (List separately in addition to code for primary procedure)  |                       |
| 22110  | Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; cervical |                       |
| 22112  | thoracic   |                       |
| 22114  | lumbar   |                       |
| 22116  | each additional vertebral segment (List separately in addition to code for primary procedure)  |                       |
| 22206  | Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (eg, pedicle/vertebral body subtraction); thoracic              |                       |
| 22207  | lumbar   |                       |
| 22208  | each additional vertebral segment (List separately in addition to code for primary procedure)  |                       |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description  | Comments/ Limitations |
|--|--|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |  |                       |
| 22210  | Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; cervical  |                       |
| 22212  | thoracic   |                       |
| 22214  | lumbar   |                       |
| 22216  | each additional vertebral segment<br>(List separately in addition to primary procedure)  |                       |
| 22220  | Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; cervical  |                       |
| 22222  | thoracic   |                       |
| 22224  | lumbar   |                       |
| 22226  | each additional vertebral segment<br>(List separately in addition to code for primary procedure)   |                       |
| 22505  | Manipulation of spine requiring anesthesia, any region   |                       |
| 22510  | Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic |                       |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description   | Comments/ Limitations |
|--|---|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |   |                       |
| 22511  | lumbosacral   |                       |
| 22512  | each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure)   |                       |
| 22513  | Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic |                       |
| 22514  | lumbar  |                       |
| 22515  | each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)   |                       |
| 22526  | Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level   |                       |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description   | Comments/ Limitations |
|---|---|-----------------------|
| <b>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</b> |   |                       |
| 22527   | 1 or more additional levels (List separately in addition to code for primary procedure)   |                       |
| 22532   | Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic                             |                       |
| 22533   | lumbar  |                       |
| 22534   | thoracic or lumbar, each additional vertebral segment (List separately in addition to code for primary procedure)   |                       |
| 22548   | Arthrodesis, anterior transoral or extraoral technique, clivus-C1-C2 (atlas-axis), with or without excision of odontoid process                                       |                       |
| 22551   | Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2 |                       |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description  | Comments/ Limitations |
|--|--|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |  |                       |
| 22552  | cervical below C2, each additional interspace (List separately in addition to code for primary procedure)  |                       |
| 22554  | Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2  |                       |
| 22556  | thoracic   |                       |
| 22558  | lumbar   |                       |
| 22585  | each additional interspace (List separately in addition to code for primary procedure)   |                       |
| 22586  | Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace |                       |
| 22590  | Arthrodesis, posterior technique, craniocervical (occiput-C2)  |                       |
| 22595  | Arthrodesis, posterior technique, atlas-axis (C1-C2)   |                       |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description   | Comments/ Limitations |
|--|---|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |   |                       |
| 22600  | Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment   |                       |
| 22610  | thoracic (with lateral transverse technique, when performed)  |                       |
| 22612  | lumbar (with lateral transverse technique, when performed)  |                       |
| 22614  | each additional vertebral segment (List separately in addition to code for primary procedure)   |                       |
| 22630  | Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar |                       |
| 22632  | each additional interspace (List separately in addition to code for primary procedure)  |                       |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description   | Comments/ Limitations |
|--|---|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |   |                       |
| 22633  | Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar |                       |
| 22634  | each additional interspace and segment (List separately in addition to code for primary procedure)  |                       |
| 22800  | Arthrodesis, posterior, for spinal deformity, with or without cast; up to 6 vertebral segments  |                       |
| 22802  | 7 to 12 vertebral segments  |                       |
| 22804  | 13 or more vertebral segments   |                       |
| 22818  | Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements); single or 2 segments   |                       |
| 22819  | 3 or more segments  |                       |
| 22830  | Exploration of spinal fusion  |                       |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description   | Comments/ Limitations |
|--|---|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |   |                       |
| 22840  | Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure) |                       |
| 22841  | Internal spinal fixation by wiring of spinous processes (List separately in addition to code for primary procedure)   |                       |
| 22842  | Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure)   |                       |
| 22843  | 7 to 12 vertebral segments (List separately in addition to code for primary procedure)  |                       |
| 22844  | 13 or more vertebral segments (List separately in addition to code for primary procedure)   |                       |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description   | Comments/ Limitations |
|--|---|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |   |                       |
| 22845  | Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure)   |                       |
| 22846  | 4 to 7 vertebral segments (List separately in addition to code for primary procedure)   |                       |
| 22847  | 8 or more vertebral segments (List separately in addition to code for primary procedure)  |                       |
| 22848  | Pelvic fixation (attachment of caudal end of instrumentation to pelvic bony structures) other than sacrum (List separately in addition to code for primary procedure) |                       |
| 22849  | Reinsertion of spinal fixation device   |                       |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description   | Comments/ Limitations |
|--|---|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |   |                       |
| 22853  | Insertion of interbody biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (List separately in addition to code for primary procedure)  |                       |
| 22854  | Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to vertebral corpectomy (ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure) |                       |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description  | Comments/ Limitations |
|--|--|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |  |                       |
| 22856  | Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophyctomy for nerve root or spinal cord decompression and microdissection); single interspace, cervical  |                       |
| 22857  | Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar   |                       |
| 22858  | second level, cervical (List separately in addition to code for primary procedure)   |                       |
| 22859  | Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh, methylmethacrylate) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure) |                       |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description  | Comments/ Limitations |
|--|--|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |  |                       |
| 22860  | Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); second interspace, lumbar (List separately in addition to code for primary procedure) | Effective 1/1/2023    |
| 22861  | Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical  |                       |
| 22862  | lumbar   |                       |
| 22864  | Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical   |                       |
| 22865  | lumbar   |                       |
| 22899  | Unlisted procedure, spine  |                       |
| 27412  | Autologous chondrocyte implantation, knee  |                       |
| 27415  | Osteochondral allograft, knee, open  |                       |
| 27416  | Osteochondral autograft(s), knee, open (eg, mosaicplasty) (includes harvesting of autograft[s])  |                       |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description                                | Comments/ Limitations |
|---|--|-----------------------|
| <b>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</b> |  |                       |
| 29867   | osteochondral allograft (eg, mosaicplasty)           |                       |
| 30120   | Excision or surgical planning of skin for rhinophyma |                       |
| 30400   | Rhinoplasty  |                       |
| 30410   | Rhinoplasty  |                       |
| 30420   | Rhinoplasty  |                       |
| 30430   | Rhinoplasty  |                       |
| 30435   | Rhinoplasty  |                       |
| 30450   | Rhinoplasty  |                       |
| 30520   | Septoplasty or submucous resection                   |                       |
| 30999   | Unlisted procedure – nose                            |                       |
| 31660   | Bronchial Thermoplasty                               |                       |
| 31661   | with bronchial thermoplasty, 2 or more lobes         |                       |
| 32851   | Transplant – lung                                    |                       |
| 32852   | Transplant – lung                                    |                       |
| 32853   | Transplant – lung                                    |                       |
| 32854   | Transplant – lung                                    |                       |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description  | Comments/ Limitations |
|--|--|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |  |                       |
| 33267  | Exclusion of left atrial appendage, open, any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip)   | Effective 9/1/22      |
| 33269  | Exclusion of left atrial appendage, thoracoscopic, any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip)  | Effective 9/1/22      |
| 33882  | Endovascular repair of the thoracic aorta by deployment of a branched endograft multipiece system involving an aorto-aortic tube device with a fenestration for the left subclavian artery stent graft(s) and all aortic tube endograft extension(s) placed from the level of the left common carotid artery to the celiac artery, including pre-procedure sizing and device selection, all target zone angioplasty, all nonselective catheterization(s) and left subclavian artery selective catheterization(s), and all associated radiological supervision and interpretation | Effective 5/1/26      |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description   | Comments/ Limitations  |
|--|---|------------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |   |                        |
| 33927  | Implantation of a total replacement heart system(artificial heart) with recipient cardiectomy     |                        |
| 33928  | Removal and replacement of total replacement heart system. (artificial heart)                     |                        |
| 33935  | Transplant – heart/lung   |                        |
| 33945  | Transplant – heart  |                        |
| 35602  | Bypass graft, with other than vein; carotid-contralateral carotid                                 | Effective 5/1/26       |
| 36260  | Insertion of implantable intra-arterial infusion pump (eg, for chemotherapy of liver)             |                        |
| 36465  | multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vein), same leg | Effective June 1, 2021 |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description   | Comments/ Limitations  |
|--|---|------------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |   |                        |
| 36466  | Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (eg, great saphenous vein, accessory saphenous vein). | Effective June 1, 2021 |
| 36470  | Injection of sclerosing solution  |                        |
| 36471  | Injection of sclerosing solution  |                        |
| 36473  | Endovenous mechanochemical destruction - 1st vein- imaging guidance   | Effective 1/1/2021     |
| 36474  | Endovenous mechanochemical destruction - 1st vein- imaging guidance   | Effective 1/1/2021     |
| 36475  | Endovenous ablation therapy - radiofrequency  |                        |
| 36476  | Endovenous ablation therapy - radiofrequency  |                        |
| 36478  | Endovenous ablation therapy - laser   |                        |
| 36479  | Endovenous ablation therapy - laser   |                        |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description  | Comments/ Limitations |
|--|--|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |  |                       |
| 36482  | Endovenous chemical destruction vein arm or leg, 1st   | Effective 1/1/2021    |
| 36483  | Endovenous chemical destruction vein arm or leg, subsequent  | Effective 1/1/2021    |
| 37254  | Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, initial vessel | Effective 5/1/26      |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description  | Comments/ Limitations |
|--|--|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |  |                       |
| 37255  | Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure) | Effective 5/1/26      |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description   | Comments/ Limitations                               |
|---|---|---|
| <p style="text-align: center; color: red;">Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</p> |   |   |
| <p style="text-align: center;">37256</p>  | <p>Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, initial vessel</p> | <p style="text-align: center;">Effective 5/1/26</p> |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description  | Comments/ Limitations |
|--|--|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |  |                       |
| 37257  | Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure) | Effective 5/1/26      |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description  | Comments/ Limitations   |
|---|--|-------------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</p> |  |                         |
| <p>37258</p>  | <p>Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel</p> | <p>Effective 5/1/26</p> |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description  | Comments/ Limitations   |
|---|--|-------------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</p> |  |                         |
| 37259   | <p>Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)</p> | <p>Effective 5/1/26</p> |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description   | Comments/ Limitations |
|--|---|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |   |                       |
| 37260  | Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel | Effective 5/1/26      |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description  | Comments/ Limitations   |
|---|--|-------------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</p> |  |                         |
| <p>37261</p>  | <p>Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)</p> | <p>Effective 5/1/26</p> |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description  | Comments/ Limitations |
|--|--|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |  |                       |
| 37262  | Intravascular lithotripsy(ies), iliac vascular territory, including all imaging guidance and radiological supervision and interpretation necessary to perform the intravascular lithotripsy(ies) within the same artery (List separately in addition to code for primary procedure)  | Effective 5/1/26      |
| 37263  | Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, initial vessel | Effective 5/1/26      |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description   | Comments/ Limitations   |
|---|---|-------------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</p> |   |                         |
| <p>37264</p>  | <p>Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)</p> | <p>Effective 5/1/26</p> |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description  | Comments/ Limitations |
|---|--|-----------------------|
| <p style="text-align: center; color: red;">Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</p> |  |                       |
| 37265   | Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, initial vessel | Effective 5/1/26      |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description   | Comments/ Limitations   |
|---|---|-------------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</p> |   |                         |
| <p>37266</p>  | <p>Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)</p> | <p>Effective 5/1/26</p> |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description  | Comments/ Limitations   |
|---|--|-------------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</p> |  |                         |
| <p>37267</p>  | <p>Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel</p> | <p>Effective 5/1/26</p> |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description  | Comments/ Limitations   |
|---|--|-------------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</p> |  |                         |
| <p>37268</p>  | <p>Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)</p> | <p>Effective 5/1/26</p> |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description  | Comments/ Limitations   |
|---|--|-------------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</p> |  |                         |
| <p>37269</p>  | <p>Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel</p> | <p>Effective 5/1/26</p> |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description  | Comments/ Limitations                               |
|---|--|---|
| <p style="text-align: center; color: red;">Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</p> |  |   |
| <p style="text-align: center;">37270</p>  | <p>Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)</p> | <p style="text-align: center;">Effective 5/1/26</p> |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description  | Comments/ Limitations   |
|---|--|-------------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</p> |  |                         |
| <p>37271</p>  | <p>Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel</p> | <p>Effective 5/1/26</p> |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description  | Comments/ Limitations   |
|---|--|-------------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</p> |  |                         |
| <p>37272</p>  | <p>Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)</p> | <p>Effective 5/1/26</p> |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description  | Comments/ Limitations                               |
|---|--|---|
| <p style="text-align: center; color: red;">Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</p> |  |   |
| <p style="text-align: center;">37273</p>  | <p>Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel</p> | <p style="text-align: center;">Effective 5/1/26</p> |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description  | Comments/ Limitations   |
|---|--|-------------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</p> |  |                         |
| <p>37274</p>  | <p>Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)</p> | <p>Effective 5/1/26</p> |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description  | Comments/ Limitations |
|--|--|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |  |                       |
| 37275  | Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel | Effective 5/1/26      |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description   | Comments/ Limitations   |
|---|---|-------------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</p> |   |                         |
| <p>37276</p>  | <p>Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)</p> | <p>Effective 5/1/26</p> |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description   | Comments/ Limitations                               |
|---|---|---|
| <p style="text-align: center; color: red;">Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</p> |   |   |
| <p style="text-align: center;">37277</p>  | <p>Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel</p> | <p style="text-align: center;">Effective 5/1/26</p> |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description   | Comments/ Limitations   |
|---|---|-------------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</p> |   |                         |
| <p>37278</p>  | <p>Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)</p> | <p>Effective 5/1/26</p> |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description  | Comments/ Limitations |
|---|--|-----------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</p> |  |                       |
| 37279   | Intravascular lithotripsy(ies), femoral and popliteal vascular territory, including all imaging guidance and radiological supervision and interpretation necessary to perform the intravascular lithotripsy(ies) within the same artery (List separately in addition to code for primary procedure)  | Effective 5/1/26      |
| 37280   | Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, initial vessel | Effective 5/1/26      |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description   | Comments/ Limitations   |
|---|---|-------------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</p> |   |                         |
| <p>37281</p>  | <p>Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)</p> | <p>Effective 5/1/26</p> |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description   | Comments/ Limitations   |
|---|---|-------------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</p> |   |                         |
| <p>37282</p>  | <p>Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, initial vessel</p> | <p>Effective 5/1/26</p> |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description   | Comments/ Limitations   |
|---|---|-------------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</p> |   |                         |
| <p>37283</p>  | <p>Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)</p> | <p>Effective 5/1/26</p> |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description  | Comments/ Limitations   |
|---|--|-------------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</p> |  |                         |
| <p>37284</p>  | <p>Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel</p> | <p>Effective 5/1/26</p> |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description  | Comments/ Limitations   |
|---|--|-------------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</p> |  |                         |
| <p>37285</p>  | <p>Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)</p> | <p>Effective 5/1/26</p> |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description  | Comments/ Limitations   |
|---|--|-------------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</p> |  |                         |
| <p>37286</p>  | <p>Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel</p> | <p>Effective 5/1/26</p> |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description   | Comments/ Limitations |
|--|---|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |   |                       |
| 37287  | Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure) | Effective 5/1/26      |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description   | Comments/ Limitations |
|---|---|-----------------------|
| <p style="color: red; text-align: center;">Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</p> |   |                       |
| 37288   | Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel | Effective 5/1/26      |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description  | Comments/ Limitations                               |
|---|--|---|
| <p style="text-align: center; color: red;">Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</p> |  |   |
| <p style="text-align: center;">37289</p>  | <p>Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)</p> | <p style="text-align: center;">Effective 5/1/26</p> |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description  | Comments/ Limitations   |
|---|--|-------------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</p> |  |                         |
| <p>37290</p>  | <p>Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel</p> | <p>Effective 5/1/26</p> |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description  | Comments/ Limitations   |
|---|--|-------------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</p> |  |                         |
| <p>37291</p>  | <p>Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)</p> | <p>Effective 5/1/26</p> |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description   | Comments/ Limitations   |
|---|---|-------------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</p> |   |                         |
| <p>37292</p>  | <p>Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel</p> | <p>Effective 5/1/26</p> |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description   | Comments/ Limitations   |
|---|---|-------------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</p> |   |                         |
| <p>37293</p>  | <p>Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)</p> | <p>Effective 5/1/26</p> |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description   | Comments/ Limitations   |
|---|---|-------------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</p> |   |                         |
| <p>37294</p>  | <p>Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel</p> | <p>Effective 5/1/26</p> |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description  | Comments/ Limitations |
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| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |  |                       |
| 37295  | Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure) | Effective 5/1/26      |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description  | Comments/ Limitations   |
|---|--|-------------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</p> |  |                         |
| <p>37296</p>  | <p>Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, initial vessel</p> | <p>Effective 5/1/26</p> |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description  | Comments/ Limitations   |
|---|--|-------------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</p> |  |                         |
| 37297   | <p>Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)</p> | <p>Effective 5/1/26</p> |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description  | Comments/ Limitations   |
|---|--|-------------------------|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</p> |  |                         |
| <p>37298</p>  | <p>Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, initial vessel</p> | <p>Effective 5/1/26</p> |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description   | Comments/ Limitations |
|--|---|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |   |                       |
| 37299  | Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure) | Effective 5/1/26      |
| 37700  | Ligation/division/stripping/stab phlebectomy  | Effective 5/1/26      |
| 37718  | Ligation/division/stripping/stab phlebectomy  | Effective 5/1/26      |
| 37722  | Ligation/division/stripping/stab phlebectomy  | Effective 5/1/26      |
| 37735  | Ligation/division/stripping/stab phlebectomy  | Effective 5/1/26      |
| 37760  | Ligation/division/stripping/stab phlebectomy  | Effective 5/1/26      |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description  | Comments/ Limitations |
|---|--|-----------------------|
| <b>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</b> |  |                       |
| 37761   | Ligation/division/stripping/stab phlebectomy   | Effective 5/1/26      |
| 37765   | Ligation/division/stripping/stab phlebectomy   | Effective 5/1/26      |
| 37766   | Ligation/division/stripping/stab phlebectomy   | Effective 5/1/26      |
| 37780   | Ligation/division/stripping/stab phlebectomy   | Effective 5/1/26      |
| 37785   | Ligation/division/stripping/stab phlebectomy   | Effective 5/1/26      |
| 38240   | Transplant – bone marrow   | Effective 5/1/26      |
| 38241   | Transplant – bone marrow   | Effective 5/1/26      |
| 38242   | Transplant – bone marrow   | Effective 5/1/26      |
| 41899   | dental procedure   | Effective 5/1/26      |
| 42145   | Palatopharyngoplasty   | Effective 5/1/26      |
| 43284   | Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band), including cruroplasty when performed | Effective 5/1/2020    |
| 43285   | Removal of esophageal sphincter augmentation device  | Effective 5/1/2020    |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description  | Comments/ Limitations |
|---|--|-----------------------|
| <b>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</b> |  |                       |
| 43289   | Unlisted laparoscopy, surgical, esophageal sphincter augmentation                                  | Effective 5/1/2020    |
| 43290   | Esophagogastroduodenoscopy, flexible, transoral; with deployment of intragastric bariatric balloon | Effective 1/1/2023    |
| 43291   | Esophagogastroduodenoscopy, flexible, transoral; with of intragastric bariatric balloon(s)         | Effective 1/1/2023    |
| 43497   | Lower esophageal myotomy, transoral (ie, peroral endoscopic myotomy [POEM])                        | Effective 9/1/22      |
| 43633   | Gastrectomy, partial, distal; with Roux-en-Y reconstruction  | Effective 7/1/2020    |
| 43644   | Lap Gastric Bypass w/Roux-en-Y   |                       |
| 43645   | Gastric Bypass w/small intestine reconstruction to limit absorption                                |                       |
| 43659   | Unlisted lap procedure, stomach  |                       |
| 43770   | Lap Band   |                       |
| 43771   | Revision of adjustable gastric restrictive device component only                                   |                       |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description  | Comments/ Limitations |
|--|--|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |  |                       |
| 43772  | Laparoscopy, surgical, gastric restrictive procedure, of adjustable gastric restrictive device component only.   |                       |
| 43773  | & replacement of Lap Band  |                       |
| 43774  | Laparoscopy, surgical, gastric restrictive procedure, of adjustable gastric restrictive device and subcutaneous port components  |                       |
| 43775  | Sleeve Gastrectomy   |                       |
| 43842  | Gastric restrictive procedure, without gastric bypass, for morbid obesity: vertical-banded gastroplasty  |                       |
| 43843  | Gastric restrictive procedure, w/o gastric bypass, other than vertical-banded gastroplasty   |                       |
| 43845  | Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch) |                       |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description   | Comments/ Limitations |
|--|---|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |   |                       |
| 43846  | Gastric Bypass w/Roux-en-Y  |                       |
| 43847  | Gastric Bypass w/small intestine reconstruction to limit absorption   |                       |
| 43848  | Revision of gastric restrictive procedure, other than adjustable gastric restrictive device   |                       |
| 43860  | Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; without vagotomy |                       |
| 43865  | Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; with vagotomy    |                       |
| 43886  | Gastric restrictive procedure; open; revision of subcutaneous port component only   |                       |
| 43887  | Gastric restrictive procedure, open; of subcutaneous port component only  |                       |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description   | Comments/ Limitations |
|---|---|-----------------------|
| <b>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</b> |   |                       |
| 43888   | Gastric restrictive procedure, open; and replacement of subcutaneous port component only  |                       |
| 43889   | Gastric restrictive procedure, transoral, endoscopic sleeve gastropasty (ESG), including argon plasma coagulation, when performed | Effective 5/1/26      |
| 43999   | Gastric Outlet Repair Unlisted procedure, stomach   |                       |
| 44135   | Transplant – small intestine  |                       |
| 44136   | Transplant – small intestine  |                       |
| 47135   | Transplant-Liver  |                       |
| 48160   | Transplant – pancreas   |                       |
| 48554   | Transplant – pancreas   |                       |
| 50360   | Transplant – kidney   |                       |
| 50365   | Transplant – kidney   |                       |
| 50380   | Transplant – kidney   |                       |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description   | Comments/ Limitations |
|--|---|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |   |                       |
| 52597  | Transurethral robotic-assisted waterjet resection of prostate, including intraoperative planning, ultrasound guidance, control of postoperative bleeding, complete, including vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy, when performed | Effective 5/1/26      |
| 58720  | Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)  |                       |
| 58940  | Oophorectomy, partial or total, unilateral or bilateral.  |                       |
| 61736  | Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; single trajectory for 1 simple lesion  | Effective 9/1/22      |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description   | Comments/ Limitations                     |
|--|---|---|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |   |   |
| 61737  | Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; multiple trajectories for multiple or complex lesion(s)                              | Effective 9/1/22                          |
| 61863  | Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site  | Effective 1/1/25                          |
| 61867  | Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site  | Effective 1/1/25                          |
| 61889  | Insertion of skull-mounted cranial neurostimulator pulse generator or receiver, including craniectomy or craniotomy, when performed, with direct or inductive coupling, with connection to depth and/or cortical strip electrode array(s) | Effective 1/1/2024 (added on 5/1/24 list) |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description  | Comments/ Limitations |
|--|--|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |  |                       |
| 62380  | Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar |                       |
| 63001  | Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; cervical   |                       |
| 63003  | thoracic   |                       |
| 63005  | lumbar, except for spondylolisthesis   |                       |
| 63012  | Laminectomy with of abnormal facets and/or pars interarticularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure)                            |                       |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description   | Comments/ Limitations |
|--|---|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |   |                       |
| 63015  | Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), more than 2 vertebral segments; cervical |                       |
| 63016  | thoracic  |                       |
| 63017  | lumbar  |                       |
| 63020  | Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical               |                       |
| 63030  | 1 interspace, lumbar  |                       |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description  | Comments/ Limitations |
|--|--|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |  |                       |
| 63032  | Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; with repair of annular defect by implantation of bone-anchored annular closure device, including all imaging guidance, 1 interspace, lumbar (List separately in addition to code for primary procedure) | Effective 5/1/26      |
| 63035  | each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)   |                       |
| 63040  | Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; cervical  |                       |
| 63042  | lumbar   |                       |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description   | Comments/ Limitations |
|--|---|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |   |                       |
| 63043  | each additional cervical interspace<br>(List separately in addition to code for primary procedure)  |                       |
| 63044  | each additional lumbar interspace<br>(List separately in addition to code for primary procedure)  |                       |
| 63045  | Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; cervical |                       |
| 63046  | thoracic  |                       |
| 63047  | lumbar  |                       |
| 63048  | each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)  |                       |
| 63050  | Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments;  |                       |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description  | Comments/ Limitations |
|--|--|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |  |                       |
| 63051  | with reconstruction of the posterior bony elements (including the application of bridging bone graft and non-segmental fixation devices [eg, wire, suture, mini-plates], when performed)   |                       |
| 63052  | Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure) | Effective 9/1/22      |
| 63053  | Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; each additional segment (List separately in addition to code for primary procedure)  | Effective 9/1/22      |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description  | Comments/ Limitations |
|--|--|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |  |                       |
| 63055  | Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; thoracic |                       |
| 63056  | lumbar (including transfacet, or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disc)                                    |                       |
| 63057  | each additional segment, thoracic or lumbar (List separately in addition to code for primary procedure)  |                       |
| 63075  | Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace                 |                       |
| 63076  | cervical, each additional interspace (List separately in addition to code for primary procedure)   |                       |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description  | Comments/ Limitations |
|--|--|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |  |                       |
| 63081  | Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment   |                       |
| 63082  | cervical, each additional segment (List separately in addition to code for primary procedure)  |                       |
| 63085  | Vertebral corpectomy (vertebral body resection), partial or complete, transthoracic approach with decompression of spinal cord and/or nerve root(s); thoracic, single segment                                    |                       |
| 63086  | thoracic, each additional segment (List separately in addition to code for primary procedure)  |                       |
| 63087  | Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic or lumbar; single segment |                       |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description   | Comments/ Limitations |
|--|---|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |   |                       |
| 63088  | each additional segment (List separately in addition to code for primary procedure)   |                       |
| 63090  | Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; single segment |                       |
| 63091  | each additional segment (List separately in addition to code for primary procedure)   |                       |
| 63101  | Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retropulsed bone fragments); thoracic, single segment   |                       |
| 63102  | lumbar, single segment  |                       |
| 63103  | thoracic or lumbar, each additional segment (List separately in addition to code for primary procedure)   |                       |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description  | Comments/ Limitations |
|--|--|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |  |                       |
| 63185  | Laminectomy with rhizotomy; 1 or 2 segments  |                       |
| 63190  | more than 2 segments   |                       |
| 63191  | Laminectomy with section of spinal accessory nerve   |                       |
| 63200  | Laminectomy, with release of tethered spinal cord, lumbar  |                       |
| 63250  | Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord; cervical           |                       |
| 63252  | thoracolumbar  |                       |
| 63265  | Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; cervical |                       |
| 63267  | lumbar   |                       |
| 63270  | Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; cervical               |                       |
| 63272  | lumbar   |                       |
| 63275  | Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, cervical                          |                       |
| 63277  | extradural, lumbar   |                       |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description   | Comments/ Limitations |
|---|---|-----------------------|
| <b>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</b> |   |                       |
| 63280   | intradural, extramedullary, cervical  |                       |
| 63282   | intradural, extramedullary, lumbar  |                       |
| 63285   | intradural, intramedullary, cervical  |                       |
| 63287   | intradural, intramedullary,<br>thoracolumbar  |                       |
| 63290   | combined extradural-intradural<br>lesion, any level   |                       |
| 63300   | Vertebral corpectomy (vertebral body<br>resection), partial or complete, for<br>excision of intraspinal lesion, single<br>segment; extradural, cervical |                       |
| 63301   | extradural, thoracic by transthoracic<br>approach   |                       |
| 63302   | extradural, thoracic by thoracolumbar<br>approach   |                       |
| 63303   | extradural, lumbar or sacral by<br>transperitoneal or retroperitoneal<br>approach   |                       |
| 63304   | intradural, cervical  |                       |
| 63305   | intradural, thoracic by transthoracic<br>approach   |                       |
| 63306   | intradural, thoracic by thoracolumbar<br>approach   |                       |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description  | Comments/ Limitations |
|--|--|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |  |                       |
| 63307  | intradural, lumbar or sacral by transperitoneal or retroperitoneal approach  |                       |
| 63308  | each additional segment (List separately in addition to codes for single segment)  |                       |
| 63620  | Stereotactic radiosurgery  |                       |
| 63650  | Percutaneous implantation of neurostimulator electrode array, epidural   |                       |
| 63655  | Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural   |                       |
| 63662  | of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed  |                       |
| 63685  | Insertion or replacement of spinal neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver |                       |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description  | Comments/ Limitations |
|---|--|-----------------------|
| <b>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</b> |  |                       |
| 63688   | Revision or of implanted spinal neurostimulator pulse generator or receiver, with detachable connection to electrode array                   |                       |
| 63707   | Repair of dural/cerebrospinal fluid leak, not requiring laminectomy  |                       |
| 63709   | Repair of dural/cerebrospinal fluid leak or pseudomeningocele, with laminectomy  |                       |
| 64553   | Percutaneous implantation of neurostimulator electrode array; cranial nerve  | Effective 1/1/25      |
| 64555   | Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)                                       | Effective 1/1/25      |
| 64561   | Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including image guidance, if performed |                       |
| 64567   | Percutaneous electrical nerve field stimulation, cranial nerves, without implantation  | Effective 5/1/26      |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description  | Comments/ Limitations |
|--|--|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |  |                       |
| 64568  | Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator   | Effective 6/1/2021    |
| 64575  | Open implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)   | Effective 1/1/25      |
| 64581  | Open implantation of neurostimulator electrode array; sacral nerve (transforaminal placement)  | Effective 1/1/25      |
| 64582  | Open implantation of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array  | Effective 9/1/22      |
| 64590  | Insertion or replacement of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver | Effective 7/1/2020    |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description   | Comments/ Limitations |
|---|---|-----------------------|
| <b>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</b> |   |                       |
| 64596   | Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator, including imaging guidance, when performed; initial electrode array                      | Effective 1/1/25      |
| 64628   | Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; first 2 vertebral bodies, lumbar or sacral   | Effective 9/1/22      |
| 64629   | Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; each additional vertebral body, lumbar or sacral (List separately in addition to code for primary procedure) | Effective 9/1/22      |
| 64999   | Unlisted procedure, nervous system  | Effective 5/1/26      |
| 65781   | limbal stem cell allograft (eg, cadaveric or living donor)  |                       |
| 67900   | Repair of brow ptosis, blepharoptosis   |                       |
| 67901   | Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)  |                       |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description  | Comments/ Limitations |
|---|--|-----------------------|
| <b>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</b> |  |                       |
| 67902   | Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia) |                       |
| 67903   | Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach                          |                       |
| 67904   | Repair of blepharoptosis; (tarso) levator resection or advancement, external approach                          |                       |
| 67906   | Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)             |                       |
| 67908   | Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type)      |                       |
| 67911   | Correction of lid retraction   |                       |
| 67914   | Repair of ectropion  |                       |
| 67915   | Repair of ectropion; thermocauterization   |                       |
| 67916   | Repair of ectropion; excision tarsal wedge   |                       |
| 67917   | Repair of ectropion; extensive (eg, tarsal strip operations)   |                       |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description   | Comments/ Limitations |
|--|---|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |   |                       |
| 67921  | Repair of entropion, suture   |                       |
| 67922  | Repair of entropion;<br>thermocauterization   |                       |
| 67923  | Repair of entropion; excision tarsal<br>wedge   |                       |
| 67924  | Repair of entropion; extensive (eg,<br>tarsal strip or capsulopalpebral fascia<br>repairs operation)                        |                       |
| 67950  | Canthoplasty  |                       |
| 67999  | Unlisted procedure, eyelids   |                       |
| 69300  | Otoplasty - protruding ear  |                       |
| 69716  | Implantation, osseointegrated<br>implant, skull; with magnetic<br>transcutaneous attachment to<br>external speech processor | Effective 9/1/22      |
| 69719  | , osseointegrated implant, skull; with<br>percutaneous attachment to external<br>speech processor                           | Effective 9/1/22      |
| 69726  | , osseointegrated implant, skull; with<br>percutaneous attachment to external<br>speech processor                           | Effective 9/1/22      |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description   | Comments/ Limitations |
|--|---|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |   |                       |
| 69727  | , osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor  | Effective 9/1/22      |
| 69728  | , entire osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex         |                       |
| 69729  | Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside of the mastoid and resulting in removal of greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex |                       |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description  | Comments/ Limitations |
|--|--|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |  |                       |
| 69730  | Replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex | Effective 1/1/23      |
| 90867  | Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management  |                       |
| 90868  | Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, subsequent delivery and management, per session  |                       |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description   | Comments/ Limitations |
|--|---|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |   |                       |
| 90869  | Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, subsequent motor threshold re- determination with delivery and management              |                       |
| 95782  | younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist   |                       |
| 95783  | younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist |                       |
| 95801  | minimum of heart rate, oxygen saturation, and respiratory analysis (eg, by airflow or peripheral arterial tone)   |                       |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description  | Comments/ Limitations |
|--|--|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |  |                       |
| 95805  | Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness              |                       |
| 95808  | Polysomnography; any age, sleep staging with 1-3 additional parameters of sleep, attended by a technologist  |                       |
| 95810  | age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist  |                       |
| 95811  | age 6 years or older, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist |                       |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description   | Comments/ Limitations |
|--|---|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |   |                       |
| 96116  | Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report         |                       |
| 96121  | each additional hour (List separately in addition to code for primary procedure)  |                       |
| 96130  | Psychological testing evaluation services by physician or other qualified healthcare professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour |                       |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description  | Comments/ Limitations |
|--|--|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |  |                       |
| 96131  | each additional hour (List separately in addition to code for primary procedure)   |                       |
| 96132  | Neuropsychological testing evaluation services by physician or other qualified healthcare professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour |                       |
| 96133  | each additional hour (List separately in addition to code for primary procedure)   |                       |
| 96136  | Psychological or neuropsychological test administration and scoring by physician or other qualified healthcare professional, two or more tests, any method; first 30 minutes   |                       |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description   | Comments/ Limitations |
|---|---|-----------------------|
| <b>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</b> |   |                       |
| 96137   | each additional 30 minutes (List separately in addition to code for primary procedure)  |                       |
| 96138   | Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes                          |                       |
| 96139   | each additional 30 minutes (List separately in addition to code for primary procedure)  |                       |
| 96146   | Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only |                       |
| <b>** 96365 if &gt;\$7500</b>   | Hydration, Therapeutic, Prophylactic, Diagnostic Injections and Infusions, and Chemotherapy and Other Highly Complex Drug or Highly Co.                     | Effective 10.1.23     |
| <b>** 96366 if &gt;\$7500</b>   | Hydration, Therapeutic, Prophylactic, Diagnostic Injections and Infusions, and Chemotherapy and Other Highly Complex Drug                                   | Effective 10.1.23     |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description   | Comments/ Limitations   |
|---|---|---|
| <b>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</b> |   |   |
| 96920   | Excimer laser treatment for psoriasis; total area less than 250 sq cm | Effective 1/1/2022  |
| 96921   | Excimer laser treatment for psoriasis; 250 sq cm to 500 sq cm         | Effective 1/1/2022  |
| 96922   | Excimer laser treatment for psoriasis; over 500 sq cm                 | Effective 1/1/2022  |
| 97151   | ABA assessment  | <a href="#">Effective 1/1/24. Please use ABA form located on the Prior Authorization Page of the <u><a href="https://mysmarthealth.org">mysmarthealth.org</a></u> website for this request.</a> |
| 97152   | ABA assessment  | <a href="#">Effective 1/1/24. Please use ABA form located on the Prior Authorization Page of the <u><a href="https://mysmarthealth.org">mysmarthealth.org</a></u> website for this request.</a> |
| 97153   | Adaptive Behavior Treatment   | <a href="#">Effective 1/1/24. Please use ABA form located on the Prior Authorization Page of the <u><a href="https://mysmarthealth.org">mysmarthealth.org</a></u> website for this request.</a> |

| CPT, HCPCS<br>or Revenue Code   | Procedure Description   | Comments/ Limitations  |
|---|---|--|
| <p>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</p> |   |  |
| 97154   | Adaptive behavior treatment with protocol modification  | <a href="#">Effective 1/1/24. Please use ABA form located on the Prior Authorization Page of the mysmarthealth.org website for this request.</a> |
| 97155   | Adaptive behavior treatment by protocol   | <a href="#">Effective 1/1/24. Please use ABA form located on the Prior Authorization Page of the mysmarthealth.org website for this request.</a> |
| 97156   | Family adaptive behavior treatment guidance   | <a href="#">Effective 1/1/24. Please use ABA form located on the Prior Authorization Page of the mysmarthealth.org website for this request.</a> |
| 97157   | multiple patients' adaptive behavior treatment face-to-face with a group of guardians or caregivers | <a href="#">Effective 1/1/24. Please use ABA form located on the Prior Authorization Page of the mysmarthealth.org website for this request.</a> |
| 97158   | Group adaptive behavior treatment with protocol modification,                                       | <a href="#">Effective 1/1/24. Please use ABA form located on the Prior Authorization Page of the mysmarthealth.org website for this request.</a> |

| CPT, HCPCS<br>or Revenue Code  | Procedure Description  | Comments/ Limitations |
|--|--|-----------------------|
| Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here. |  |                       |
| 99183  | Hyperbaric Oxygen Therapy (HBO Therapy)  | Effective 1/1/2021    |
| 99499  | Transplant evaluations (general code used for all types).  |                       |
| ** S2066, S2067, S2068 **  | These are non-covered codes. Please use the proper procedure codes instead: 19361, 19364, 19366, 19367, 19368, or 19369. | Effective 1/1/2020    |

| CPT, HCPCS<br>or Revenue<br>Code  | Radiology Description  | Comments/ Limitations |
|---|--|-----------------------|
| <b>Please note any elective procedure done as an inpatient also requires authorization even if the code is not listed here.</b> |  |                       |
| 61715   | Stereotaxis Procedures on the Skull, Meninges, and Brain   | Effective 1/1/25      |
| 70336   | MRI temporomandibular joint(s)   |                       |
| 70540   | MRI orbit, face and /or neck; w/o contrast   |                       |
| 70542   | MRI orbit, face and /or neck; w/o contrast   |                       |
| 70543   | MRI orbit, face and /or neck; w/o contrast followed by contrast  |                       |
| 70544   | Magnetic resonance angiography, head; without contrast material(s)   |                       |
| 70545   | with contrast material(s)  |                       |
| 70546   | without contrast material(s), followed by contrast material(s) and further sequences   |                       |
| 70547   | MRA neck; w/o contrast   |                       |
| 70548   | MRA neck; with contrast  |                       |
| 70549   | MRA neck; w/o contrast followed by contrast  |                       |
| 70551   | MRI brain; w/o contrast  |                       |
| 70552   | MRI brain; with contrast   |                       |
| 70553   | MRI brain; w/o contrast followed by contrast   |                       |
| 70554   | Functional MRI; not requiring physician or psychologist administration   |                       |
| 70555   | Functional MRI; requiring physician or psychologist administration of entire   |                       |
| 70557   | Magnetic resonance (eg, proton) imaging, brain (including brain stem and skull base), during open intracranial procedure (eg, to assess for residual tumor or residual vascular malformation); without contrast material |                       |
| 70558   | with contrast material(s)  |                       |
| 70559   | without contrast material(s), followed by contrast material(s) and further sequences   |                       |
| 71550   | MRI chest; w/o contrast  |                       |
| 71551   | MRI chest; with contrast   |                       |
| 71552   | MRI chest; w/o contrast followed by contrast   |                       |

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|-------|--|--|
| 71555 | MRA chest; with or w/o contrast  |  |
| 72141 | MRI cervical spine; w/o contrast   |  |
| 72142 | MRI cervical spine; with contrast  |  |
| 72146 | MRI thoracic spine, w/o contrast   |  |
| 72147 | MRI thoracic spine; with contrast  |  |
| 72148 | MRI lumbar spine; w/o contrast   |  |
| 72149 | MRI lumbar spine; with contrast  |  |
| 72156 | MRI cervical spine; w/o contrast followed by contrast                        |  |
| 72157 | MRI thoracic spine; w/o contrast followed by contrast                        |  |
| 72158 | MRI lumbar spine; w/o contrast followed by contrast                          |  |
| 72159 | MRA spinal canal and contents; with or w/o contrast                          |  |
| 72195 | MRI pelvis; w/o contrast   |  |
| 72196 | MRI pelvis; with contrast  |  |
| 72197 | MRI pelvis; w/o contrast followed by contrast                                |  |
| 72198 | MRA pelvis; with or w/o contrast   |  |
| 73218 | MRI upper extremity; other than joint w/o contrast                           |  |
| 73219 | MRI upper extremity; other than joint with contrast                          |  |
| 73220 | MRI upper extremity; other than joint w/o contrast followed by contrast      |  |
| 73221 | MRI upper extremity; any joint w/o contrast                                  |  |
| 73222 | MRI upper extremity; any joint with contrast                                 |  |
| 73223 | MRI upper extremity; any joint w/o contrast followed by contrast             |  |
| 73225 | MRA upper extremity; with or w/o contrast                                    |  |
| 73718 | MRI lower extremity, other than joint w/o contrast                           |  |
| 73719 | MRI lower extremity, other than joint with contrast                          |  |
| 73720 | MRI lower extremity, other than joint, without contrast followed by contrast |  |
| 73721 | MRI lower extremity, any joint, w/o contrast                                 |  |

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|-------|--|--------------------|
| 73722 | MRI lower extremity, any joint with contrast   |                    |
| 73723 | MRI lower extremity, any joint w/o contrast followed by contrast                             |                    |
| 73725 | MRA lower extremity; with or w/o contrast  |                    |
| 74181 | MRI abdomen; w/o contrast  |                    |
| 74182 | MRI abdomen; with contrast   |                    |
| 74183 | MRI abdomen; w/o contrast followed by contrast   |                    |
| 74185 | MRA abdomen; with or w/o contrast  |                    |
| 74712 | Magnetic resonance (eg, proton) imaging, fetal, including placental and maternal pelvic      |                    |
| 74713 | each additional gestation (List separately in addition to code for primary procedure)        |                    |
| 75557 | MRI cardiac; morphology and function w/o contrast  |                    |
| 75559 | MRI cardiac; morphology and function w/o contrast material; with stress                      |                    |
| 75561 | MRI cardiac; morphology and function w/o contrast followed by contrast and                   |                    |
| 75563 | MRI cardiac; morphology and function w/o contrast followed by contrast and                   |                    |
| 75565 | Cardiac magnetic resonance imaging for velocity flow mapping (List separately in addition to |                    |
| 76390 | Magnetic resonance spectroscopy  |                    |
| 76391 | MRI Elastography   |                    |
| 76498 | Unlisted magnetic resonance procedure (eg, diagnostic, interventional)                       |                    |
| 77021 | Magnetic resonance imaging guidance for needle placement (eg, for biopsy, needle             |                    |
| 77022 | Magnetic resonance imaging guidance for, and monitoring of, parenchymal tissue ablation      |                    |
| 77046 | MRI breast; without contrast; unilateral   |                    |
| 77047 | MRI breast; with contrast; bilateral   |                    |
| 77048 | MRI breast; without and with contrast material(s), including computer-aided detection (CAD   |                    |
| 77049 | MRI breast; without and with contrast material(s), including computer-aided detection (CAD   |                    |
| 77084 | MRI bone marrow blood supply   |                    |
| 77436 | Surface radiation therapy; superficial or orthovoltage, treatment planning and simulation-   | Effective 5/1/2026 |
| 77437 | Surface radiation therapy; superficial, delivery,  | Effective 5/1/2026 |

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|-------|---|--------------------|
| 77438 | Surface radiation therapy; orthovoltage, delivery, >150-500 kV, per fraction                    | Effective 5/1/2026 |
| 77439 | Surface radiation therapy; superficial or orthovoltage, image guidance, ultrasound for          | Effective 5/1/2026 |
| 77520 | Proton treatment delivery; simple, without compensation   |                    |
| 77522 | simple, with compensation   |                    |
| 77523 | intermediate  |                    |
| 77525 | complex   |                    |
| 78102 | Bone marrow imaging; limited area   |                    |
| 78103 | multiple areas  |                    |
| 78104 | whole body  |                    |
| 78429 | Myocardial imaging, positron emission tomography (PET), metabolic evaluation study              | Effective 9/1/2020 |
| 78430 | Myocardial imaging, positron emission tomography (PET), perfusion study (including              | Effective 9/1/2020 |
| 78431 | Myocardial imaging, positron emission tomography (PET), perfusion study (including              | Effective 9/1/2020 |
| 78432 | Myocardial imaging, positron emission tomography (PET), combined perfusion with                 | Effective 9/1/2020 |
| 78433 | Myocardial imaging, positron emission tomography (PET), combined perfusion with                 | Effective 9/1/2020 |
| 78434 | Absolute quantitation of myocardial blood flow (AQMBF), positron emission tomography            | Effective 9/1/2020 |
| 78451 | Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction,            |                    |
| 78452 | multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution       |                    |
| 78453 | Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion,        |                    |
| 78454 | multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution       |                    |
| 78459 | Myocardial imaging, positron emission tomography (PET), metabolic evaluation study              |                    |
| 78466 | Myocardial imaging, infarct avid, planar; qualitative or quantitative                           |                    |
| 78468 | with ejection fraction by first pass technique  |                    |
| 78469 | tomographic SPECT with or without quantification  |                    |
| 78472 | Cardiac blood pool imaging, gated equilibrium; planar, single study at rest or stress (exercise |                    |
| 78473 | multiple studies, wall motion study plus ejection fraction, at rest and stress (exercise and/or |                    |
| 78481 | Cardiac blood pool imaging (planar), first pass technique; single study, at rest or with stress |                    |

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|--------|--|--------------------|
| 78483  | multiple studies, at rest and with stress (exercise and/or pharmacologic), wall motion study   |                    |
| 78491  | Myocardial imaging, positron emission tomography (PET), perfusion study (including             |                    |
| 78492  | Myocardial imaging, positron emission tomography (PET), perfusion study (including             |                    |
| 78494  | Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection |                    |
| 78496  | Cardiac blood pool imaging, gated equilibrium, single study, at rest, with right ventricular   |                    |
| 78499  | Unlisted cardiovascular procedure, diagnostic nuclear medicine                                 |                    |
| 78608  | PET of brain for metabolic evaluation  |                    |
| 78609  | PET of brain for perfusion evaluation  |                    |
| 78811  | PET IMAGING LIMITED AREA CHEST HEAD/NECK   |                    |
| 78812  | PET imaging of skull base to mid-thigh   |                    |
| 78813  | PET imaging of entire body   |                    |
| 78814  | PET IMAGING CT FOR ATTENUATION LIMITED AREA  |                    |
| 78815  | PET IMAGING CT ATTENUATION SKULL BASE MID-THIGH  |                    |
| 78816  | PET IMAGING FOR CT ATTENUATION WHOLE BODY  |                    |
| 91113  | Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with              | Effective 9.1.2022 |
| C030BZ | PET IMAGING, BRAIN, C-11   |                    |
| C030KZ | PET IMAGING, BRAIN, F-18   |                    |
| C030MZ | PET IMAGING, BRAIN, O-15   |                    |
| C030YZ | PET IMAGING, BRAIN, OTHER RADIONUCLIDE   |                    |
| C03YYZ | PET IMAGING, CNS, OTHER RADIONUCLIDE   |                    |
| C23GKZ | PET IMAGING, MYOCARDIUM, F-18  |                    |
| C23GM  | HEART, PET IMAGING, MYOCARDIUM, O-15   |                    |
| C23GMZ | PET IMAGING, MYOCARDIUM, O-15  |                    |
| C23GQZ | PET IMAGING, MYOCARDIUM, RB-82   |                    |
| C23GRZ | PET IMAGING, MYOCARDIUM, N-13  |                    |
| C23GYZ | PET IMAGING, MYOCARDIUM, OTHER RADIONUCLIDE  |                    |

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|--------|---|--|
| C23YYZ | PET IMAGING, HEART, OTHER RADIONUCLIDE        |  |
| CB32KZ | PET IMAGING, LUNGS & BRONCHI, F-18            |  |
| CB32YZ | PET IMAGING, LUNG & BRONCHI, OTH RADIONUCLIDE |  |
| CB3YYZ | PET IMAGING, RESP SYST, OTHER RADIONUCLIDE    |  |
| CW3NYZ | PET IMAGING, WHOLE BODY, OTHER RADIONUCLIDE   |  |
| G0219  | PET imaging whole body; melanoma              |  |
| G0235  | PET not otherwise specified                   |  |
| G0252  | PET imaging initial dx                        |  |

| CPT, HCPCS<br>or Revenue Code   | LAB Description   | Comments/ Limitations   |
|---|---|---|
| <b>All genetic testing codes require review and preauthorization.</b> |   |   |
| 81120   | IDH1 (ISOCITRATE DEHYDROGENASE 1 [NADP+], SOLUBLE) (EG, GLIOMA), COMMON VARIANTS (EG, R132H, R132C)   |   |
| 81121   | IDH2 (ISOCITRATE DEHYDROGENASE 2 [NADP+], MITOCHONDRIAL) (EG, GLIOMA), COMMON VARIANTS (EG, R140W, R172M)   |   |
| 81161   | DMD (dystrophin) (eg, Duchenne/Becker muscular dystrophy) deletion analysis, and duplication analysis, if performed   |   |
| 81162   | BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis and full duplication/deletion analysis (ie, detection of large gene rearrangements) | Effective 1.1.23 Prior Authorization requirements are waived when billed with any of the following diagnosis codes: Z15.01, Z15.02, Z31.5, Z80.3, Z80.41, Z85.3, Z85.43, Z85.44 |
| 81163   | BRCA full sequence analysis   | Effective 1.1.23 Prior Authorization requirements are waived when billed with any of the following diagnosis codes: Z15.01, Z15.02, Z31.5, Z80.3, Z80.41, Z85.3, Z85.43, Z85.44 |
| 81164   | BRCA full duplication/deletion analysis (ie, detection of large gene rearrangements)  | Effective 1.1.23 Prior Authorization requirements are waived when billed with any of the following diagnosis codes: Z15.01, Z15.02, Z31.5, Z80.3, Z80.41, Z85.3, Z85.43, Z85.44 |
| 81165   | BRCA1 (BRCA1, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis   | Effective 1.1.23 Prior Authorization requirements are waived when billed with any of the following diagnosis codes: Z15.01, Z15.02, Z31.5, Z80.3, Z80.41, Z85.3, Z85.43, Z85.44 |
| 81166   | BRCA1 (BRCA1, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (ie, detection of large gene rearrangements)  | Effective 1.1.23 Prior Authorization requirements are waived when billed with any of the following diagnosis codes: Z15.01, Z15.02, Z31.5, Z80.3, Z80.41, Z85.3, Z85.43, Z85.44 |

| CPT, HCPCS<br>or Revenue Code   | LAB Description  | Comments/ Limitations   |
|---|--|---|
| <b>All genetic testing codes require review and preauthorization.</b> |  |   |
| 81167   | BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (ie, detection of large gene rearrangements)   | Effective 1.1.23 Prior Authorization requirements are waived when billed with any of the following diagnosis codes: Z15.01, Z15.02, Z31.5, Z80.3, Z80.41, Z85.3, Z85.43, Z85.44 |
| 81170   | ABL1 (ABL proto-oncogene 1, non-receptor tyrosine kinase) (eg, acquired imatinib tyrosine kinase inhibitor resistance), gene analysis, variants in the kinase domain   |   |
| 81171   | AFF2 (ALF transcription elongation factor 2 [FMR2]) (eg, fragile X intellectual disability 2 [FRAXE]) gene analysis; evaluation to detect abnormal (eg, expanded) alleles  |   |
| 81172   | AFF2 (ALF transcription elongation factor 2 [FMR2]) (eg, fragile X intellectual disability 2 [FRAXE]) gene analysis; characterization of alleles (eg, expanded size and methylation status)                              |   |
| 81173   | AR (androgen receptor) (eg, spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation) gene analysis; characterization of alleles (eg, expanded size or methylation status), full gene sequence     |   |
| 81174   | AR (androgen receptor) (eg, spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation) gene analysis; characterization of alleles (eg, expanded size or methylation status), known familial variant |   |
| 81175   | ASXL1 (additional sex combs like 1, transcriptional regulator) (eg, myelodysplastic syndrome, myeloproliferative neoplasms, chronic myelomonocytic leukemia), gene analysis; full gene sequence                          |   |
| 81176   | ASXL1 (additional sex combs like 1, transcriptional regulator) (eg, myelodysplastic syndrome, myeloproliferative neoplasms, chronic myelomonocytic leukemia), gene analysis; targeted sequence analysis (eg, exon 12)    |   |
| 81177   | ATN1 (atrophin 1) (eg, dentatorubral-pallidoluysian atrophy) gene analysis, evaluation to detect abnormal (eg, expanded) alleles   |   |
| 81178   | ATXN1 (ataxin 1) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles  |   |
| 81179   | ATXN2 (ataxin 2) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles  |   |
| 81180   | ATXN3 (ataxin 3) (eg, spinocerebellar ataxia, Machado-Joseph disease) gene analysis, evaluation to detect abnormal (eg, expanded) alleles  |   |
| 81181   | ATXN7 (ataxin 7) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles  |   |
| 81182   | ATXN8OS (ATXN8 opposite strand [non-protein coding]) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles  |   |

| CPT, HCPCS<br>or Revenue Code   | LAB Description  | Comments/ Limitations |
|---|--|-----------------------|
| <b>All genetic testing codes require review and preauthorization.</b> |  |                       |
| 81183   | ATXN10 (ataxin 10) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles  |                       |
| 81184   | CACNA1A (calcium voltage-gated channel subunit alpha1 A) (eg, spinocerebellar ataxia) gene analysis; evaluation to detect abnormal (eg, expanded) alleles  |                       |
| 81185   | full gene sequence   |                       |
| 81186   | CACNA1A (calcium voltage-gated channel subunit alpha1 A) (eg, spinocerebellar ataxia) gene analysis; known familial variant  |                       |
| 81187   | CNBP (CCHC-type zinc finger nucleic acid binding protein) (eg, myotonic dystrophy type 2) gene analysis, evaluation to detect abnormal (eg, expanded) alleles                                    |                       |
| 81188   | CSTB (cystatin B) (eg, Unverricht-Lundborg disease) gene analysis; evaluation to detect abnormal (eg, expanded) alleles  |                       |
| 81189   | MGMT (O-6-METHYLGUANINE-DNA METHYLTRANSFERASE) (EG, GLIOBLASTOMA MULTIFORME) PROMOTER METHYLATION ANALYSIS   |                       |
| 81190   | CSTB (cystatin B) (eg, Unverricht-Lundborg disease) gene analysis; known familial variant(s)   |                       |
| 81200   | ASPA (aspartoacylase) (eg, Canavan disease) gene analysis, common variants (eg, E285A, Y231X)  |                       |
| 81201   | APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; full gene sequence   |                       |
| 81202   | APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; known familial variants  |                       |
| 81203   | APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; known familial variants  |                       |
| 81204   | AR (androgen receptor) (eg, spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation) gene analysis; characterization of alleles (eg, expanded size or methylation status) |                       |
| 81205   | BCKDHB (branched-chain keto acid dehydrogenase E1, beta polypeptide) (eg, maple syrup urine disease) gene analysis, common variants (eg, R183P, G278S, E422X)                                    |                       |
| 81206   | BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; major breakpoint, qualitative or quantitative  |                       |
| 81207   | BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; minor breakpoint, qualitative or quantitative  |                       |
| 81208   | BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; other breakpoint, qualitative or quantitative  |                       |
| 81209   | BLM (Bloom syndrome, RecQ helicase-like) (eg, Bloom syndrome) gene analysis, 2281del6ins7 variant  |                       |
| 81210   | BRAF (B-Raf proto-oncogene, serine/threonine kinase) (eg, colon cancer, melanoma), gene analysis, V600 variant(s)  |                       |

| CPT, HCPCS<br>or Revenue Code   | LAB Description  | Comments/ Limitations   |
|---|--|---|
| <b>All genetic testing codes require review and preauthorization.</b> |  |   |
| 81212   | BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; 185delAG, 5385insC, 6174delT variants | Effective 1.1.23 Prior Authorization requirements are waived when billed with any of the following diagnosis codes: Z15.01, Z15.02, Z31.5, Z80.3, Z80.41, Z85.3, Z85.43, Z85.44 |
| 81215   | BRCA1 (BRCA1, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; known familial variant  | Effective 1.1.23 Prior Authorization requirements are waived when billed with any of the following diagnosis codes: Z15.01, Z15.02, Z31.5, Z80.3, Z80.41, Z85.3, Z85.43, Z85.44 |
| 81216   | BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis  | Effective 1.1.23 Prior Authorization requirements are waived when billed with any of the following diagnosis codes: Z15.01, Z15.02, Z31.5, Z80.3, Z80.41, Z85.3, Z85.43, Z85.44 |
| 81217   | known familial variant   | Effective 1.1.23 Prior Authorization requirements are waived when billed with any of the following diagnosis codes: Z15.01, Z15.02, Z31.5, Z80.3, Z80.41, Z85.3, Z85.43, Z85.44 |
| 81218   | CEBPA (CCAAT/enhancer binding protein [C/EBP], alpha) (eg, acute myeloid leukemia), gene analysis, full gene sequence  |   |
| 81219   | CALR (calreticulin) (eg, myeloproliferative disorders), gene analysis, common variants in exon 9   |   |
| 81220   | CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; common variants (eg, ACMG/ACOG guidelines)                                 |   |
| 81221   | known familial variants  |   |
| 81222   | duplication/deletion variants  |   |
| 81223   | full gene sequence   |   |
| 81224   | CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; intron 8 poly-T analysis (eg, male infertility)                            |   |
| 81225   | CYP2C19 (cytochrome P450, family 2, subfamily C, polypeptide 19) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *8, *17)                           |   |

| CPT, HCPCS<br>or Revenue Code   | LAB Description  | Comments/ Limitations |
|---|--|-----------------------|
| <b>All genetic testing codes require review and preauthorization.</b> |  |                       |
| 81226   | CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *5, *6, *9, *10, *17, *19, *29, *35, *41, *1XN, *2XN, *4XN)  |                       |
| 81227   | CYP2C9 (cytochrome P450, family 2, subfamily C, polypeptide 9) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *5, *6)  |                       |
| 81228   | Cytogenomic constitutional (genome-wide) microarray analysis; interrogation of genomic regions for copy number variants (eg, bacterial artificial chromosome [BAC] or oligo-based comparative genomic hybridization [CGH] microarray analysis) |                       |
| 81229   | Cytogenomic constitutional (genome-wide) microarray analysis; interrogation of genomic regions for copy number and single nucleotide polymorphism (SNP) variants for chromosomal abnormalities   |                       |
| 81230   | CYP3A4 (cytochrome P450 family 3 subfamily A member 4) (eg, drug metabolism), gene analysis, common variant(s) (eg, *2, *22)   |                       |
| 81231   | CYP3A5 (cytochrome P450 family 3 subfamily A member 5) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *5, *6, *7)  |                       |
| 81232   | DPYD (dihydropyrimidine dehydrogenase) (eg, 5-fluorouracil/5-FU and capecitabine drug metabolism), gene analysis, common variant(s) (eg, *2A, *4, *5, *6)  |                       |
| 81233   | BTK (Bruton's tyrosine kinase) (eg, chronic lymphocytic leukemia) gene analysis, common variants (eg, C481S, C481R, C481F)   |                       |
| 81234   | DMPK (DM1 protein kinase) (eg, myotonic dystrophy type 1) gene analysis; evaluation to detect abnormal (expanded) alleles  |                       |
| 81235   | EGFR (epidermal growth factor receptor) (eg, non-small cell lung cancer) gene analysis, common variants (eg, exon 19 LREA deletion, L858R, T790M, G719A, G719S, L861Q)   |                       |
| 81236   | EZH2 (enhancer of zeste 2 polycomb repressive complex 2 subunit) (eg, myelodysplastic syndrome, myeloproliferative neoplasms) gene analysis, full gene sequence  |                       |
| 81237   | EZH2 (enhancer of zeste 2 polycomb repressive complex 2 subunit) (eg, diffuse large B-cell lymphoma) gene analysis, common variant(s) (eg, codon 646)  |                       |
| 81238   | F9 (coagulation factor IX) (eg, hemophilia B), full gene sequence  |                       |
| 81239   | DMPK (DM1 protein kinase) (eg, myotonic dystrophy type 1) gene analysis; characterization of alleles (eg, expanded size)   |                       |
| 81240   | F2 (prothrombin, coagulation factor II) (eg, hereditary hypercoagulability) gene analysis, 20210G>A variant  |                       |
| 81241   | F5(Coagulation Factor V) (eg; hereditary hypercoagulability) gene analysis, 20120G>A variant   |                       |
| 81242   | FANCC (Fanconi anemia, complementation group C) (eg, Fanconi anemia, type C) gene analysis, common variant (eg, IVS4+4A>T)   |                       |
| 81243   | FMR1 (fragile X messenger ribonucleoprotein 1) (eg, fragile X syndrome, X-linked intellectual disability [XLID]) gene analysis; evaluation to detect abnormal (eg, expanded) alleles   |                       |

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| 81244   | FMR1 (fragile X messenger ribonucleoprotein 1) (eg, fragile X syndrome, X-linked intellectual disability [XLID]) gene analysis; characterization of alleles (eg, expanded size and promoter methylation status)  |                       |
| 81245   | Solid organ neoplasm, genomic sequence analysis panel, 5-50 genes, interrogation for sequence variants and copy number variants or rearrangements, if performed; DNA analysis or combined DNA and RNA analysis   |                       |
| 81246   | FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia), gene analysis; tyrosine kinase domain (TKD) variants (eg, D835, I836)   |                       |
| 81247   | G6PD (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice), gene analysis; common variant(s) (eg, A, A-)  |                       |
| 81248   | G6PD (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice), gene analysis; known familial variant(s)  |                       |
| 81249   | G6PD (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice), gene analysis; full gene sequence   |                       |
| 81250   | G6PC (glucose-6-phosphatase, catalytic subunit) (eg, Glycogen storage disease, type 1a, von Gierke disease) gene analysis, common variants (eg, R83C, Q347X)   |                       |
| 81251   | GBA (glucosidase, beta, acid) (eg, Gaucher disease) gene analysis, common variants (eg, N370S, 84GG, L444P, IVS2+1G>A)   |                       |
| 81252   | GJB2 (gap junction protein, beta 2, 26kDa, connexin 26) (eg, nonsyndromic hearing loss) gene analysis; full gene sequence  |                       |
| 81253   | GJB2 (gap junction protein, beta 2, 26kDa, connexin 26) (eg, nonsyndromic hearing loss) gene analysis; known familial variants   |                       |
| 81254   | GJB6 (gap junction protein, beta 6, 30kDa, connexin 30) (eg, nonsyndromic hearing loss) gene analysis, common variants (eg, 309kb [del(GJB6-D13S1830)] and 232kb [del(GJB6-D13S1854)])   |                       |
| 81255   | HEXA (hexosaminidase A [alpha polypeptide]) (eg, Tay-Sachs disease) gene analysis, common variants (eg, 1278insTATC, 1421+1G>C, G269S)   |                       |
| 81256   | HFE (hemochromatosis) (eg, hereditary hemochromatosis) gene analysis, common variants (eg, C282Y, H63D)  |                       |
| 81257   | HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; common deletions or variant (eg, Southeast Asian, Thai, Filipino, Mediterranean, alpha3.7, alpha4.2, alpha 20.5, Constant Spring) |                       |
| 81258   | HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; known familial variant  |                       |
| 81259   | HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; full gene sequence  |                       |
| 81260   | IKBKAP (inhibitor of kappa light polypeptide gene enhancer in B-cells, kinase complex-associated protein) (eg, familial dysautonomia) gene analysis, common variants (eg, 2507+6T>C, R696P)  |                       |

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| 81261   | IGH@ (Immunoglobulin heavy chain locus) (eg, leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); amplified methodology (eg, polymerase chain reaction)  |                       |
| 81262   | IGH@ (Immunoglobulin heavy chain locus) (eg, leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); direct probe methodology (eg, Southern blot)   |                       |
| 81263   | IGH@ (Immunoglobulin heavy chain locus) (eg, leukemia and lymphoma, B-cell), variable region somatic mutation analysis   |                       |
| 81264   | IGK@ (Immunoglobulin kappa light chain locus) (eg, leukemia and lymphoma, B-cell), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)   |                       |
| 81265   | Comparative analysis using Short Tandem Repeat (STR) markers; patient and comparative specimen (eg, pre-transplant recipient and donor germline testing, post-transplant non-hematopoietic recipient germline [eg, buccal swab or other germline tissue sample] and donor testing, twin zygosity testing, or maternal cell contamination of fetal cells) |                       |
| 81266   | Comparative analysis using Short Tandem Repeat (STR) markers; each additional specimen (eg, additional cord blood donor, additional fetal samples from different cultures, or additional zygosity in multiple birth pregnancies) (List separately in addition to code for primary procedure)   |                       |
| 81269   | HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; duplication/deletion variants   |                       |
| 81270   | JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, p.Val617Phe (V617F) variant   |                       |
| 81271   | HTT (huntingtin) (eg, Huntington disease) gene analysis; evaluation to detect abnormal (eg, expanded) alleles  |                       |
| 81272   | KIT (v-kit Hardy-Zuckerman 4 feline sarcoma viral oncogene homolog) (eg, gastrointestinal stromal tumor [GIST], acute myeloid leukemia, melanoma), gene analysis, targeted sequence analysis (eg, exons 8, 11, 13, 17, 18)   |                       |
| 81273   | KIT (v-kit Hardy-Zuckerman 4 feline sarcoma viral oncogene homolog) (eg, mastocytosis), gene analysis, D816 variant(s)   |                       |
| 81274   | characterization of alleles (eg, expanded size)  |                       |
| 81275   | KRAS (Kirsten rat sarcoma viral oncogene homolog) (eg, carcinoma) gene analysis; variants in exon 2 (eg, codons 12 and 13)   |                       |
| 81276   | KRAS (Kirsten rat sarcoma viral oncogene homolog) (eg, carcinoma) gene analysis; additional variant (s) (eg, codon 61, codon 146)  |                       |
| 81277   | Cytogenomic neoplasia (genome-wide) microarray analysis, interrogation of genomic regions for copy number and loss-of-heterozygosity variants for chromosomal abnormalities  |                       |
| 81279   | JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) targeted sequence analysis (eg, exons 12 and 13)   | Effective 1/1/2021    |
| 81283   | IFNL3 (interferon, lambda 3) (eg, drug response), gene analysis, rs12979860 variant  |                       |

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| <b>All genetic testing codes require review and preauthorization.</b> |  |                       |
| 81284   | FXN (frataxin) (eg, Friedreich ataxia) gene analysis; evaluation to detect abnormal (expanded) alleles   |                       |
| 81285   | FXN (frataxin) (eg, Friedreich ataxia) gene analysis; evaluation to detect abnormal (expanded) alleles; characterization of alleles (eg, expanded size)  |                       |
| 81286   | FXN (frataxin) (eg, Friedreich ataxia) gene analysis; evaluation to detect abnormal (expanded) alleles; full gene sequence   |                       |
| 81287   | MGMT (O-6-METHYLGUANINE-DNA METHYLTRANSFERASE) (EG, GLIOBLASTOMA MULTIFORME) PROMOTER METHYLATION ANALYSIS   |                       |
| 81288   | MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; promoter methylation analysis   |                       |
| 81289   | FXN (frataxin) (eg, Friedreich ataxia) gene analysis; evaluation to detect abnormal (expanded) alleles: known familial variant(s)  |                       |
| 81290   | MCOLN1 (mucolipin 1) (eg, Mucopolipidosis, type IV) gene analysis, common variants (eg, IVS3-2A>G, del6.4kb)   |                       |
| 81291   | MTHFR (5,10-methylenetetrahydrofolate reductase) (eg, hereditary hypercoagulability) gene analysis, common variants (eg, 677T, 1298C)  |                       |
| 81292   | MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis  |                       |
| 81293   | MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants   |                       |
| 81294   | MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis, full sequence analysis or known familial variants or duplication/deletion variants          |                       |
| 81295   | MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis  |                       |
| 81296   | MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants   |                       |
| 81297   | MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants   |                       |
| 81298   | MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis   |                       |
| 81299   | MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants  |                       |
| 81300   | MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants  |                       |
| 81301   | Microsatellite instability analysis (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) of markers for mismatch repair deficiency (eg, BAT25, BAT26), includes comparison of neoplastic and normal tissue, if performed |                       |

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| 81302   | MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; full sequence analysis   |                       |
| 81303   | known familial variant   |                       |
| 81304   | duplication/deletion variants  |                       |
| 81305   | MYD88 (myeloid differentiation primary response 88) (eg, Waldenstrom's macroglobulinemia, lymphoplasmacytic leukemia) gene analysis, p.Leu265Pro (L265P) variant   |                       |
| 81306   | NUDT15 (nudix hydrolase 15) (eg, drug metabolism) gene analysis, common variant(s) (eg, *2, *3, *4, *5, *6)  |                       |
| 81307   | PALB2 (partner and localizer of BRCA2) (eg, breast and pancreatic cancer) gene analysis; full gene sequence  |                       |
| 81308   | PALB2 (partner and localizer of BRCA2) (eg, breast and pancreatic cancer) gene analysis; known familial variant  |                       |
| 81309   | PIK3CA (phosphatidylinositol-4, 5-biphosphate 3-kinase, catalytic subunit alpha) (eg, colorectal and breast cancer) gene analysis, targeted sequence analysis (eg, exons 7, 9, 20)                                     |                       |
| 81310   | NPM1 (nucleophosmin) (eg, acute myeloid leukemia) gene analysis, exon 12 variants  |                       |
| 81311   | NRAS (neuroblastoma RAS viral [v-ras] oncogene homolog) (eg, colorectal carcinoma), gene analysis, variants in exon 2 (eg, codons 12 and 13) and exon 3 (eg, codon 61)   |                       |
| 81312   | PABPN1 (poly[A] binding protein nuclear 1) (eg, oculopharyngeal muscular dystrophy) gene analysis, evaluation to detect abnormal (eg, expanded) alleles  |                       |
| 81313   | PCA3/KLK3 (prostate cancer antigen 3 [non-protein coding]/kallikrein-related peptidase 3 [prostate specific antigen]) ratio (eg, prostate cancer)  |                       |
| 81314   | PDGFRA (platelet-derived growth factor receptor, alpha polypeptide) (eg, gastrointestinal stromal tumor [GIST]), gene analysis, targeted sequence analysis (eg, exons 12, 18)  |                       |
| 81315   | PML/RARalpha, (t(15;17)), (promyelocytic leukemia/retinoic acid receptor alpha) (eg, promyelocytic leukemia) translocation analysis; common breakpoints (eg, intron 3 and intron 6), qualitative or quantitative       |                       |
| 81316   | PML/RARalpha, (t(15;17)), (promyelocytic leukemia/retinoic acid receptor alpha) (eg, promyelocytic leukemia) translocation analysis; single breakpoint (eg, intron 3, intron 6 or exon 6), qualitative or quantitative |                       |
| 81317   | PMS2 (postmeiotic segregation increased 2 [ <i>S. cerevisiae</i> ]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis   |                       |
| 81318   | PMS2 (postmeiotic segregation increased 2 [ <i>S. cerevisiae</i> ]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants  |                       |
| 81319   | PMS2 (postmeiotic segregation increased 2 [ <i>S. cerevisiae</i> ]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants                                      |                       |

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| 81320   | PLCG2 (phospholipase C gamma 2) (eg, chronic lymphocytic leukemia) gene analysis, common variants (eg, R665W, S707F, L845F)   |                       |
| 81321   | PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; full sequence analysis  |                       |
| 81322   | PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; known familial variant  |                       |
| 81323   | PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; duplication/deletion variant  |                       |
| 81324   | RUNX1 (runt related transcription factor 1) (eg, acute myeloid leukemia, familial platelet disorder with associated myeloid malignancy) gene analysis, targeted sequence analysis (eg, exons 3-8) |                       |
| 81325   | PMP22 (peripheral myelin protein 22) (eg, Charcot-Marie-Tooth, hereditary neuropathy with liability to pressure palsies) gene analysis; full sequence analysis                                    |                       |
| 81326   | PMP22 (peripheral myelin protein 22) (eg, Charcot-Marie-Tooth, hereditary neuropathy with liability to pressure palsies) gene analysis; known familial variant                                    |                       |
| 81328   | PMS2 (postmeiotic segregation increased 2 [ <i>S. cerevisiae</i> ]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants                       |                       |
| 81329   | PMS2 (postmeiotic segregation increased 2 [ <i>S. cerevisiae</i> ]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants                 |                       |
| 81330   | SMPD1(sphingomyelin phosphodiesterase 1, acid lysosomal) (eg, Niemann-Pick disease, Type A) gene analysis, common variants (eg, R496L, L302P, fsP330)   |                       |
| 81331   | SNRPN/UBE3A (small nuclear ribonucleoprotein polypeptide N and ubiquitin protein ligase E3A) (eg, Prader-Willi syndrome and/or Angelman syndrome), methylation analysis                           |                       |
| 81332   | SERPINA1 (serpin peptidase inhibitor, clade A, alpha-1 antiproteinase, antitrypsin, member 1) (eg, alpha-1-antitrypsin deficiency), gene analysis, common variants (eg, *S and *Z)                |                       |
| 81333   | TGFB1 (transforming growth factor beta-induced) (eg, corneal dystrophy) gene analysis, common variants (eg, R124H, R124C, R124L, R555W, R555Q)  |                       |
| 81334   | RUNX1 (runt related transcription factor 1) (eg, acute myeloid leukemia, familial platelet disorder with associated myeloid malignancy) gene analysis, targeted sequence analysis (eg, exons 3-8) |                       |
| 81335   | TPMT (thiopurine S-methyltransferase) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3)  |                       |
| 81336   | SMN1 (survival of motor neuron 1, telomeric) (eg, spinal muscular atrophy) gene analysis; full gene sequence  |                       |
| 81337   | SMN1 (survival of motor neuron 1, telomeric) (eg, spinal muscular atrophy) gene analysis; known familial sequence variant(s)  |                       |
| 81338   | MPL (MPL proto-oncogene, thrombopoietin receptor) (eg, myeloproliferative disorder) gene analysis; common variants (eg, W515A, W515K, W515L, W515R)   | Effective 1/1/2021    |

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| 81339   | MPL (MPL proto-oncogene, thrombopoietin receptor) (eg, myeloproliferative disorder) gene analysis; sequence analysis, exon 10  | Effective 1/1/2021    |
| 81340   | TRB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using amplification methodology (eg, polymerase chain reaction) |                       |
| 81341   | TRB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using direct probe methodology (eg, Southern blot)              |                       |
| 81342   | TRG@ (T cell antigen receptor, gamma) (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)   |                       |
| 81343   | PPP2R2B (protein phosphatase 2 regulatory subunit Bbeta) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles  |                       |
| 81344   | TBP (TATA box binding protein) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles  |                       |
| 81345   | TERT (telomerase reverse transcriptase) (eg, thyroid carcinoma, glioblastoma multiforme) gene analysis, targeted sequence analysis (eg, promoter region)   |                       |
| 81346   | TYMS (thymidylate synthetase) (eg, 5-fluorouracil/5-FU drug metabolism), gene analysis, common variant(s) (eg, tandem repeat variant)  |                       |
| 81347   | SF3B1 (splicing factor [3b] subunit B1) (eg, myelodysplastic syndrome/acute myeloid leukemia) gene analysis, common variants (eg, A672T, E622D, L833F, R625C, R625L)                                   | Effective 1/1/2021    |
| 81348   | SRSF2 (serine and arginine-rich splicing factor 2) (eg, myelodysplastic syndrome, acute myeloid leukemia) gene analysis, common variants (eg, P95H, P95L)  | Effective 1/1/2021    |
| 81349   | Cytogenomic (genome-wide) analysis for constitutional chromosomal abnormalities; interrogation of genomic regions for copy number and loss-of-heterozygosity variants, low-pass sequencing analysis    | Effective 1/1/2021    |
| 81350   | UGT1A1 (UDP glucuronosyltransferase 1 family, polypeptide A1) (eg, irinotecan metabolism), gene analysis, common variants (eg, *28, *36, *37)  |                       |
| 81351   | TP53 (tumor protein 53) (eg, Li-Fraumeni syndrome) gene analysis; full gene sequence   | Effective 1/1/2021    |
| 81352   | TP53 (tumor protein 53) (eg, Li-Fraumeni syndrome) gene analysis; targeted sequence analysis (eg, 4 oncology)  | Effective 1/1/2021    |
| 81353   | TP53 (tumor protein 53) (eg, Li-Fraumeni syndrome) gene analysis; known familial variant   | Effective 1/1/2021    |
| 81354   | Cytogenomic (genome-wide) analysis for constitutional chromosomal abnormalities; interrogation of structural and copy number variants, optical genome mapping (OGM)                                    | Effective 5/1/2026    |
| 81355   | VKORC1 (vitamin K epoxide reductase complex, subunit 1) (eg, warfarin metabolism), gene analysis, common variant(s) (eg, -1639G>A, c.173+1000C>T)  |                       |
| 81357   | U2AF1 (U2 small nuclear RNA auxiliary factor 1) (eg, myelodysplastic syndrome, acute myeloid leukemia) gene analysis, common variants (eg, S34F, S34Y, Q157R, Q157P)                                   | Effective 1/1/2021    |

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| <b>All genetic testing codes require review and preauthorization.</b> |   |                       |
| 81360   | ZRSR2 (zinc finger CCCH-type, RNA binding motif and serine/arginine-rich 2) (eg, myelodysplastic syndrome, acute myeloid leukemia) gene analysis, common variant(s) (eg, E65fs, E122fs, R448fs) | Effective 1/1/2021    |
| 81361   | HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); common variant(s) (eg, HbS, HbC, HbE)  |                       |
| 81362   | HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); known familial variant(s)  |                       |
| 81363   | HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); duplication/deletion variant(s)  |                       |
| 81364   | HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); full gene sequence   |                       |
| 81370   | HLA Class I and II typing, low resolution (eg, antigen equivalents); HLA-A, -B, -C, -DRB1/3/4/5, and -DQB1  |                       |
| 81371   | HLA Class I and II typing, low resolution (eg, antigen equivalents); HLA-A, -B, and -DRB1 (eg, verification typing)   |                       |
| 81372   | HLA Class I typing, low resolution (eg, antigen equivalents); complete (ie, HLA-A, -B, and -C)  |                       |
| 81373   | HLA Class I typing, low resolution (eg, antigen equivalents); one locus (eg, HLA-A, -B, or -C), each  |                       |
| 81374   | HLA Class I typing, low resolution (eg, antigen equivalents); one antigen equivalent (eg, B*27), each   |                       |
| 81375   | HLA Class II typing, low resolution (eg, antigen equivalents); HLA-DRB1/3/4/5 and -DQB1   |                       |
| 81376   | HLA Class II typing, low resolution (eg, antigen equivalents); one locus (eg, HLA-DRB1, -DRB3/4/5, -DQB1, -DQA1, -DPB1, or -DPA1), each   |                       |
| 81377   | HLA Class II typing, low resolution (eg, antigen equivalents); one antigen equivalent, each   |                       |
| 81378   | HLA Class I and II typing, high resolution (ie, alleles or allele groups), HLA-A, -B, -C, and -DRB1   |                       |
| 81379   | HLA Class I typing, high resolution (ie, alleles or allele groups); complete (ie, HLA-A, -B, and -C)  |                       |
| 81380   | HLA Class I typing, high resolution (ie, alleles or allele groups); one locus (eg, HLA-A, -B, or -C), each  |                       |
| 81381   | HLA Class I typing, high resolution (ie, alleles or allele groups); one allele or allele group (eg, B*57:01P), each   |                       |
| 81382   | HLA Class II typing, high resolution (ie, alleles or allele groups); one locus (eg, HLA-DRB1, -DRB3/4/5, -DQB1, -DQA1, -DPB1, or -DPA1), each   |                       |
| 81383   | HLA Class II typing, high resolution (ie, alleles or allele groups); one allele or allele group (eg, HLA-DQB1*06:02P), each   |                       |
| 81400   | Molecular pathology procedure, Level 1  |                       |
| 81401   | Molecular pathology procedure level 2   |                       |
| 81402   | Molecular pathology procedure level 3   |                       |
| 81403   | Molecular pathology procedure, Level 4  |                       |

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| <b>All genetic testing codes require review and preauthorization.</b> |   |                       |
| 81404   | Molecular pathology procedure, Level 5  |                       |
| 81405   | Molecular pathology procedure, Level 6  |                       |
| 81406   | Molecular pathology procedure, Level 7  |                       |
| 81407   | Molecular pathology procedure, Level 8  |                       |
| 81408   | Molecular pathology procedure, Level 9  |                       |
| 81410   | Aortic dysfunction or dilation (eg, Marfan syndrome, Loeys Dietz syndrome, Ehler Danlos syndrome type IV, arterial tortuosity syndrome); genomic sequence analysis panel, must include sequencing of at least 9 genes, including FBN1, TGFBR1, TGFBR2, COL3A1, MYH11, ACTA2, SLC2A10, SMAD3, and MYLK                                 |                       |
| 81411   | Duplication/deletion analysis panel, must include analyses for TGFBR1, TGFBR2, MYH11, and COL3A1  |                       |
| 81412   | Ashkenazi Jewish associated disorders (eg, Bloom syndrome, Canavan disease, cystic fibrosis, familial dysautonomia, Fanconi anemia group C, Gaucher disease, Tay-Sachs disease), genomic sequence analysis panel, must include sequencing of at least 9 genes, including ASPA, BLM, CFTR, FANCC, GBA, HEXA, IKBKAP, MCOLN1, and SMPD1 |                       |
| 81413   | Cardiac ion channelopathies (eg, Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia); genomic sequence analysis panel, must include sequencing of at least 10 genes, including ANK2, CASQ2, CAV3, KCNE1, KCNE2, KCNH2, KCNJ2, KCNQ1, RYR2, and SCN5A                        |                       |
| 81414   | Duplication/deletion gene analysis panel, must include analysis of at least 2 genes, including KCNH2 and KCNQ1  |                       |
| 81415   | Exome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis   |                       |
| 81416   | sequence analysis, each comparator exome (eg, parents, siblings) (List separately in addition to code for primary procedure)  |                       |
| 81417   | re-evaluation of previously obtained exome sequence (eg, updated knowledge or unrelated condition/syndrome)   |                       |
| 81419   | Epilepsy genomic sequence analysis panel, must include analyses for ALDH7A1, CACNA1A, CDKL5, CHD2, GABRG2, GRIN2A, KCNQ2, MECP2, PCDH19, POLG, PRRT2, SCN1A, SCN1B, SCN2A, SCN8A, SLC2A1, SLC9A6, STXBP1, SYNGAP1, TCF4, TPP1, TSC1, TSC2, and ZEB2   | Effective 1/1/2021    |
| 81422   | Fetal chromosomal microdeletion(s) genomic sequence analysis (eg, DiGeorge syndrome, Cri-du-chat syndrome), circulating cell-free fetal DNA in maternal blood   |                       |
| 81425   | Genome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis  |                       |
| 81426   | sequence analysis, each comparator genome (eg, parents, siblings) (List separately in addition to code for primary procedure)   |                       |
| 81427   | re-evaluation of previously obtained genome sequence (eg, updated knowledge or unrelated condition/syndrome)  |                       |

| CPT, HCPCS<br>or Revenue Code   | LAB Description  | Comments/ Limitations |
|---|--|-----------------------|
| <b>All genetic testing codes require review and preauthorization.</b> |  |                       |
| 81430   | Hearing loss (eg, nonsyndromic hearing loss, Usher syndrome, Pendred syndrome); genomic sequence analysis panel, must include sequencing of at least 60 genes, including CDH23, CLRN1, GJB2, GPR98, MTRNR1, MYO7A, MYO15A, PCDH15, OTOF, SLC26A4, TMC1, TMPRSS3, USH1C, USH1G, USH2A, and WFS1   |                       |
| 81431   | duplication/deletion analysis panel, must include copy number analyses for STRC and DFNB1 deletions in GJB2 and GJB6 genes   |                       |
| 81432   | Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer, hereditary pancreatic cancer, hereditary prostate cancer), genomic sequence analysis panel, 5 or more genes, interrogation for sequence variants and copy number variants  |                       |
| 81434   | Hereditary retinal disorders (eg, retinitis pigmentosa, Leber congenital amaurosis, cone-rod dystrophy), genomic sequence analysis panel, must include sequencing of at least 15 genes, including ABCA4, CNGA1, CRB1, EYS, PDE6A, PDE6B, PRPF31, PRPH2, RDH12, RHO, RP1, RP2, RPE65, RPGR, and USH2A   |                       |
| 81435   | Hereditary colon cancer-related disorders (eg, Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis), genomic sequence analysis panel, 5 or more genes, interrogation for sequence variants and copy number variants  |                       |
| 81437   | Hereditary neuroendocrine tumor-related disorders (eg, medullary thyroid carcinoma, parathyroid carcinoma, malignant pheochromocytoma or paraganglioma), genomic sequence analysis panel, 5 or more genes, interrogation for sequence variants and copy number variants  |                       |
| 81439   | Hereditary cardiomyopathy (eg, hypertrophic cardiomyopathy, dilated cardiomyopathy, arrhythmogenic right ventricular cardiomyopathy), genomic sequence analysis panel, must include sequencing of at least 5 cardiomyopathy-related genes (eg, DSG2, MYBPC3, MYH7, PKP2, TTN)  |                       |
| 81440   | Nuclear encoded mitochondrial genes (eg, neurologic or myopathic phenotypes), genomic sequence panel, must include analysis of at least 100 genes, including BCS1L, C10orf2, COQ2, COX10, DGUOK, MPV17, OPA1, PDSS2, POLG, POLG2, RRM2B, SCO1, SCO2, SLC25A4, SUCLA2, SUCLG1, TAZ, TK2, and TYMP   |                       |
| 81441   | Inherited bone marrow failure syndromes (IBMFS) (eg, Fanconi anemia, dyskeratosis congenita, Diamond-Blackfan anemia, Shwachman-Diamond syndrome, GATA2 deficiency syndrome, congenital amegakaryocytic thrombocytopenia) sequence analysis panel, must include sequencing of at least 30 genes, including BRCA2, BRIP1, DKC1, FANCA, FANCB, FANCC, FANCD2, FANCE, FANCF, FANCG, FANCI, FANCL, GATA1, GATA2, MPL, NHP2, NOP10, PALB2, RAD51C, RPL11, RPL35A, RPL5, RPS10, RPS19, RPS24, RPS26, RPS7, SBDS, TERT, and TINF2 | Effective 1/1/2023    |

| CPT, HCPCS<br>or Revenue Code   | LAB Description   | Comments/ Limitations                     |
|---|---|---|
| <b>All genetic testing codes require review and preauthorization.</b> |   |   |
| 81442   | Noonan spectrum disorders (eg, Noonan syndrome, cardio-facio-cutaneous syndrome, Costello syndrome, LEOPARD syndrome, Noonan-like syndrome), genomic sequence analysis panel, must include sequencing of at least 12 genes, including BRAF, CBL, HRAS, KRAS, MAP2K1, MAP2K2, NRAS, PTPN11, RAF1, RIT1, SHOC2, and SOS1  |   |
| 81443   | Genetic testing for severe inherited conditions (eg, cystic fibrosis, Ashkenazi Jewish-associated disorders [eg, Bloom syndrome, Canavan disease, Fanconi anemia type C, mucopolipidosis type VI, Gaucher disease, Tay-Sachs disease], beta hemoglobinopathies, phenylketonuria, galactosemia), genomic sequence analysis panel, must include sequencing of at least 15 genes (eg, ACADM, ARSA, ASPA, ATP7B, BCKDHA, BCKDHB, BLM, CFTR, DHCR7, FANCC, G6PC, GAA, GALT, GBA, GBE1, HBB, HEXA, IKBKAP, MCOLN1, PAH) |   |
| 81445   | Solid organ neoplasm, genomic sequence analysis panel, 5-50 genes, interrogation for sequence variants and copy number variants or rearrangements, if performed; DNA analysis or combined DNA and RNA analysis  |   |
| 81448   | Hereditary peripheral neuropathies (eg, Charcot-Marie-Tooth, spastic paraplegia), genomic sequence analysis panel, must include sequencing of at least 5 peripheral neuropathy-related genes (eg, BSCL2, GJB1, MFN2, MPZ, REEP1, SPAST, SPG11, SPTLC1)  |   |
| 81449   | Solid organ neoplasm, genomic sequence analysis panel, 5-50 genes, interrogation for sequence variants and copy number variants or rearrangements, if performed; RNA analysis   | Effective 1/1/2023                        |
| 81450   | Hematolymphoid neoplasm or disorder, genomic sequence analysis panel, 5-50 genes, interrogation for sequence variants, and copy number variants or rearrangements, or isoform expression or mRNA expression levels, if performed; DNA analysis or combined DNA and RNA analysis   |   |
| 81451   | Hematolymphoid neoplasm or disorder, genomic sequence analysis panel, 5-50 genes, interrogation for sequence variants, and copy number variants or rearrangements, or isoform expression or mRNA expression levels, if performed; RNA analysis  | Effective 1/1/2023                        |
| 81455   | Solid organ or hematolymphoid neoplasm or disorder, 51 or greater genes, genomic sequence analysis panel, interrogation for sequence variants and copy number variants or rearrangements, or isoform expression or mRNA expression levels, if performed; DNA analysis or combined DNA and RNA analysis  | Effective 9/1/2020                        |
| 81456   | Solid organ or hematolymphoid neoplasm or disorder, 51 or greater genes, genomic sequence analysis panel, interrogation for sequence variants and copy number variants or rearrangements, or isoform expression or mRNA expression levels, if performed; RNA analysis   | Effective 1/1/2023                        |
| 81457   | Solid organ neoplasm, genomic sequence analysis panel, interrogation for sequence variants; DNA analysis, microsatellite instability  | Effective 1/1/2024 (added on 5/1/24 list) |
| 81458   | Solid organ neoplasm, genomic sequence analysis panel, interrogation for sequence variants; DNA analysis, copy number variants and microsatellite instability   | Effective 1/1/2024 (added on 5/1/24 list) |
| 81459   | Solid organ neoplasm, genomic sequence analysis panel, interrogation for sequence variants; DNA analysis or combined DNA and RNA analysis, copy number variants, microsatellite instability, tumor mutation burden, and rearrangements  | Effective 1/1/2024 (added on 5/1/24 list) |

| CPT, HCPCS<br>or Revenue Code   | LAB Description  | Comments/ Limitations                    |
|---|--|--|
| <b>All genetic testing codes require review and preauthorization.</b> |  |  |
| 81460   | Whole mitochondrial genome (eg, Leigh syndrome, mitochondrial encephalomyopathy, lactic acidosis, and stroke-like episodes [MELAS], myoclonic epilepsy with ragged-red fibers [MERFF], neuropathy, ataxia, and retinitis pigmentosa [NARP], Leber hereditary optic neuropathy [LHON]), genomic sequence, must include sequence analysis of entire mitochondrial genome with heteroplasmy detection |  |
| 81462   | Solid organ neoplasm, genomic sequence analysis panel, cell-free nucleic acid (eg, plasma), interrogation for sequence variants; DNA analysis or combined DNA and RNA analysis, copy number variants and rearrangements  | Effective 1/1/2024 (added on 5/1/24 list |
| 81463   | Solid organ neoplasm, genomic sequence analysis panel, cell-free nucleic acid (eg, plasma), interrogation for sequence variants; DNA analysis, copy number variants, and microsatellite instability  | Effective 1/1/2024 (added on 5/1/24 list |
| 81464   | Solid organ neoplasm, genomic sequence analysis panel, cell-free nucleic acid (eg, plasma), interrogation for sequence variants; DNA analysis or combined DNA and RNA analysis, copy number variants, microsatellite instability, tumor mutation burden, and rearrangements  | Effective 1/1/2024 (added on 5/1/24 list |
| 81465   | Whole mitochondrial genome large deletion analysis panel (eg, Kearns-Sayre syndrome, chronic progressive external ophthalmoplegia), including heteroplasmy detection, if performed   |  |
| 81470   | X-linked intellectual disability (XLID) (eg, syndromic and non-syndromic XLID); genomic sequence analysis panel, must include sequencing of at least 60 genes, including ARX, ATRX, CDKL5, FGD1, FMR1, HUWE1, IL1RAPL, KDM5C, L1CAM, MECP2, MED12, MID1, OCRL, RPS6KA3, and SLC16A2  |  |
| 81471   | duplication/deletion gene analysis, must include analysis of at least 60 genes, including ARX, ATRX, CDKL5, FGD1, FMR1, HUWE1, IL1RAPL, KDM5C, L1CAM, MECP2, MED12, MID1, OCRL, RPS6KA3, and SLC16A2   |  |
| 81479   | Unlisted molecular pathology procedure   |  |
| 81490   | Autoimmune (rheumatoid arthritis), analysis of 12 biomarkers using immunoassays, utilizing serum, prognostic algorithm reported as a disease activity score  |  |
| 81493   | Coronary artery disease, mRNA, gene expression profiling by real-time RT-PCR of 23 genes, utilizing whole peripheral blood, algorithm reported as a risk score   |  |
| 81500   | Oncology (ovarian), biochemical assays of two proteins (CA-125 and HE4), utilizing serum, with menopausal status, algorithm reported as a risk score   |  |
| 81503   | Oncology (ovarian), biochemical assays of five proteins (CA-125, apolipoprotein A1, beta-2 microglobulin, transferrin, and prealbumin), utilizing serum, algorithm reported as a risk score  |  |
| 81504   | Oncology (tissue of origin), microarray gene expression profiling of > 2000 genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as tissue similarity scores   |  |
| 81506   | Endocrinology (type 2 diabetes), biochemical assays of seven analytes (glucose, HbA1c, insulin, hs-CRP, adiponectin, ferritin, interleukin 2-receptor alpha), utilizing serum or plasma, algorithm reporting a risk score  |  |

| CPT, HCPCS<br>or Revenue Code   | LAB Description   | Comments/ Limitations                     |
|---|---|---|
| <b>All genetic testing codes require review and preauthorization.</b> |   |   |
| 81508   | Fetal congenital abnormalities, biochemical assays of two proteins (PAPP-A, hCG [any form]), utilizing maternal serum, algorithm reported as a risk score   |   |
| 81509   | Fetal congenital abnormalities, biochemical assays of three proteins (PAPP-A, hCG [any form], DIA), utilizing maternal serum, algorithm reported as a risk score  |   |
| 81510   | Fetal congenital abnormalities, biochemical assays of three analytes (AFP, uE3, hCG [any form]), utilizing maternal serum, algorithm reported as a risk score   |   |
| 81511   | Fetal congenital abnormalities, biochemical assays of four analytes (AFP, uE3, hCG [any form], DIA) utilizing maternal serum, algorithm reported as a risk score (may include additional results from previous biochemical testing)   |   |
| 81512   | Fetal congenital abnormalities, biochemical assays of five analytes (AFP, uE3, total hCG, hyperglycosylated hCG, DIA) utilizing maternal serum, algorithm reported as a risk score  |   |
| 81517   | Liver disease, analysis of 3 biomarkers (hyaluronic acid [HA], procollagen III amino terminal peptide [PIIINP], tissue inhibitor of metalloproteinase 1 [TIMP-1]), using immunoassays, utilizing serum, prognostic algorithm reported as a risk score and risk of liver fibrosis and liver-related clinical events within 5 years                   | Effective 1/1/2024 (added on 5/1/24 list) |
| 81518   | Oncology (breast), mRNA, gene expression profiling by real-time RT-PCR of 11 genes (7 content and 4 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithms reported as percentage risk for metastatic recurrence and likelihood of benefit from extended endocrine therapy  |   |
| 81520   | Oncology (breast), mRNA gene expression profiling by hybrid capture of 58 genes (50 content and 8 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a recurrence risk score   |   |
| 81522   | Oncology (breast), mRNA, gene expression profiling by RT-PCR of 12 genes (8 content and 4 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as recurrence risk score   |   |
| 81523   | Oncology (breast), mRNA, next-generation sequencing gene expression profiling of 70 content genes and 31 housekeeping genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as index related to risk to distant metastasis   | Effective 1/1/2021                        |
| 81524   | Oncology (central nervous system tumor), DNA methylation analysis of at least 10,000 methylation sites, utilizing DNA extracted from formalin-fixed tumor tissue, algorithm(s) reported as probability of matching a reference tumor family and class, and MGMT (O-6-methylguanine-DNA methyltransferase) promoter methylation status, if performed | Effective 5/1/2026                        |
| 81525   | Oncology (colon), mRNA, gene expression profiling by real-time RT-PCR of 12 genes (7 content and 5 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a recurrence score   |   |
| 81529   | Oncology (cutaneous melanoma), mRNA, gene expression profiling by real-time RT-PCR of 31 genes (28 content and 3 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as recurrence risk, including likelihood of sentinel lymph node metastasis  | Effective 1/1/2021                        |

| CPT, HCPCS<br>or Revenue Code   | LAB Description   | Comments/ Limitations |
|---|---|-----------------------|
| <b>All genetic testing codes require review and preauthorization.</b> |   |                       |
| 81538   | Oncology (lung), mass spectrometric 8-protein signature, including amyloid A, utilizing serum, prognostic and predictive algorithm reported as good versus poor overall survival  |                       |
| 81540   | Oncology (tumor of unknown origin), mRNA, gene expression profiling by real-time RT-PCR of 92 genes (87 content and 5 housekeeping) to classify tumor into main cancer type and subtype, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a probability of a predicted main cancer type and subtype                             |                       |
| 81541   | Oncology (prostate), mRNA gene expression profiling by real-time RT-PCR of 46 genes (31 content and 15 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a disease-specific mortality risk score  |                       |
| 81542   | Oncology (prostate), mRNA, microarray gene expression profiling of 22 content genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as metastasis risk score   | Effective 9/1/2020    |
| 81551   | Oncology (prostate), promoter methylation profiling by real-time PCR of 3 genes (GSTP1, APC, RASSF1), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a likelihood of prostate cancer detection on repeat biopsy   |                       |
| 81552   | Oncology (uveal melanoma), mRNA, gene expression profiling by real-time RT-PCR of 15 genes (12 content and 3 housekeeping), utilizing fine needle aspirate or formalin-fixed paraffin-embedded tissue, algorithm reported as risk of metastasis   |                       |
| 81554   | Pulmonary disease (idiopathic pulmonary fibrosis [IPF]), mRNA, gene expression analysis of 190 genes, utilizing transbronchial biopsies, diagnostic algorithm reported as categorical result (eg, positive or negative for high probability of usual interstitial pneumonia [UIP])  | Effective 1/1/2021    |
| 81558   | Transplantation medicine (allograft rejection, kidney), mRNA, gene expression profiling by quantitative polymerase chain reaction (qPCR) of 139 genes, utilizing whole blood, algorithm reported as a binary categorization as transplant excellence, which indicates immune quiescence, or not transplant excellence, indicating subclinical rejection | Effective 1/1/2025    |
| 81595   | Cardiology (heart transplant), mRNA, gene expression profiling by real-time quantitative PCR of 20 genes (11 content and 9 housekeeping), utilizing subfraction of peripheral blood, algorithm reported as a rejection risk score   |                       |
| 81596   | Infectious disease, chronic hepatitis C virus (HCV) infection, six biochemical assays (ALT, A2-macroglobulin, apolipoprotein A-1, total bilirubin, GGT, and haptoglobin) utilizing serum, prognostic algorithm reported as scores for fibrosis and necroinflammatory activity in liver  |                       |
| 88237   | Cytogenetic Studies   |                       |
| 88271   | Cytogenetic Studies   |                       |
| 88275   | Cytogenetic Studies   |                       |
| 0017U   | Oncology (hematolymphoid neoplasia), JAK2 mutation, DNA, PCR amplification of exons 12-14 and sequence analysis, blood or bone marrow, report of JAK2 mutation not detected or detected   |                       |

| CPT, HCPCS<br>or Revenue Code   | LAB Description  | Comments/ Limitations                              |
|---|--|--|
| <b>All genetic testing codes require review and preauthorization.</b> |  |  |
| 0018U   | Oncology (thyroid) microRNA profiling by RT-PCR of 10 microRNA sequences, utilizing fine needle aspirate, algorithm reported as positive or negative result for moderate to high risk of malignancy. (ThyGenx formerly Mirinform Thyroid)  |  |
| 0020M   | Oncology (central nervous system), analysis of 30000 DNA methylation loci by methylation array, utilizing DNA extracted from tumor tissue, diagnostic algorithm reported as probability of matching a reference tumor subclass   | Effective 7/1/2024                                 |
| 0022U   | Targeted genomic sequence analysis panele, non-small cell lung neoplasia, DNA & RNA analysis, 23 genes, interrogation for sequence variants and rearrangements, reported as presence/absence of variants associated  |  |
| 0023U   | Oncology (Acute myelogenous leukemia) DNA, genotyping of internal tandem duplication   |  |
| 0026U   | Oncology (thyroid) DNA & mRNA of 112 genes, next hyphengeneration sequencing, fine needle aspirate of thyroid nodule, algorithmic analysis reported as categorical result (Positive, high probability of malignancy or negative, low probability of malignancy)                      |  |
| 0027U   | JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, targeted sequence analysis exons 12-15  |  |
| 0037U   | FoundationOne Proprietary Lab Analyses   | Effective 8/1/21                                   |
| 0049U   | NPM1 (nucleophosmin) (eg, acute myeloid leukemia) gene analysis, quantitative  |  |
| 0056U   | Hematology (acute myelogenous leukemia), DNA, whole genome next-generation sequencing to detect gene rearrangement(s), blood or bone marrow, report of specific gene rearrangement(s)  |  |
| 0111U   | Oncology (colon cancer), targeted KRAS (codons 12, 13, and 61) and NRAS (codons 12, 13, and 61) gene analysis utilizing formalin-fixed paraffin-embedded tissue  |  |
| 0113U   | Oncology (prostate), measurement of PCA3 and TMPRSS2-ERG in urine and PSA in serum following prostatic massage, by RNA amplification and fluorecence-based detection, algorithm reported as risk score   |  |
| 0155U   | PIK3CA (phosphatidylinositol-4,5-bisphosphate 3-kinase, catalytic subunit alpha) (eg, breast cancer) gene analysis   |  |
| 0172u   | myChoice® CDx test from Myriad Genetics  | Not Covered until 10/1/25 with prior authorization |
| 0177U   | Oncology (breast cancer), DNA, PIK3CA (phosphatidylinositol-4,5-bisphosphate 3-kinase catalytic subunit alpha) gene analysis of 11 gene variants utilizing plasma, reported as PIK3CA gene mutation status   |  |
| 0208U   | Oncology (medullary thyroid carcinoma), mRNA, gene expression analysis of 108 genes, utilizing fine needle aspirate, algorithm reported as positive or negative for medullary thyroid carcinoma  | Effective 1/1/2021                                 |
| 0211U   | Oncology (pan-tumor), DNA and RNA by next-generation sequencing, utilizing formalin-fixed paraffin-embedded tissue, interpretative report for single nucleotide variants, copy number alterations, tumor mutational burden, and microsatellite instability, with therapy association | Effective 1/1/2021                                 |

| CPT, HCPCS<br>or Revenue Code   | LAB Description  | Comments/ Limitations |
|---|--|-----------------------|
| <b>All genetic testing codes require review and preauthorization.</b> |  |                       |
| 0242U   | Targeted Genomic Sequence Analysis Panel, Solid Organ Neoplasm, Cell-Free Circulating Dna Analysis Of 55-74 Genes, Interrogation For Sequence Variants, Gene Copy Number Amplifications, And Gene Rearrangements   | Effective 4/1/2021    |
| 0244U   | Oncology (Solid Organ), Dna, Comprehensive Genomic Profiling, 257 Genes, Interrogation For Single-Nucleotide Variants, Insertions/Deletions, Copy Number Alterations, Gene Rearrangements, Tumor-Mutational Burden And Microsatellite Instability, Utilizing Formalin-Fixed Paraffin-Embedded Tumor Tissue   | Effective 4/1/2021    |
| 0245U   | Oncology (Thyroid), Mutation Analysis Of 10 Genes And 37 Rna Fusions And Expression Of 4 Mrna Markers Using Next-Generation Sequencing, Fine Needle Aspirate, Report Includes Associated Risk Of Malignancy Expressed As A Percentage  | Effective 4/1/2021    |
| 0250U   | Oncology (Solid Organ Neoplasm), Targeted Genomic Sequence Dna Analysis Of 505 Genes, Interrogation For Somatic Alterations (Snvs [Single Nucleotide Variant], Small Insertions And Deletions, One Amplification, And Four Translocations), Microsatellite Instability And Tumor-Mutation Burden   | Effective 9/1/21      |
| 0326U   | Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free circulating DNA analysis of 83 or more genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability and tumor mutational burden  | Effective 7/1/2022    |
| 0334U   | Oncology (solid organ), targeted genomic sequence analysis, formalin-fixed paraffin-embedded (FFPE) tumor tissue, DNA analysis, 84 or more genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability and tumor mutational burden  | Effective 10/1/2022   |
| 0339U   | Oncology (prostate), mRNA expression profiling of HOXC6 and DLX1, reverse transcription polymerase chain reaction (RT-PCR), first-void urine following digital rectal examination, algorithm reported as probability of high-grade cancer  | Effective 10/1/2022   |
| 0364U   | Oncology (hematolymphoid neoplasm), genomic sequence analysis using multiplex (PCR) and next-generation sequencing with algorithm, quantification of dominant clonal sequence(s), reported as presence or absence of minimal residual disease (MRD) with quantitation of disease burden, when appropriate  | Effective 10/1/2023   |
| 0471U   | Oncology (colorectal cancer), qualitative real-time PCR of 35 variants of KRAS and NRAS genes (exons 2, 3, 4), formalin-fixed paraffin-embedded (FFPE), predictive, identification of detected mutations   | Effective 7/1/2024    |
| 0473U   | Oncology (solid tumor), next-generation sequencing (NGS) of DNA from formalin-fixed paraffin-embedded (FFPE) tissue with comparative sequence analysis from a matched normal specimen (blood or saliva), 648 genes, interrogation for sequence variants, insertion and deletion alterations, copy number variants, rearrangements, microsatellite instability, and tumor-mutation burden | Effective 7/1/2024    |
| 0488U   | Obstetrics (fetal antigen noninvasive prenatal test), cell-free DNA sequence analysis for detection of fetal presence or absence of 1 or more of the Rh, C, c, D, E, Duffy (Fya), or Kell (K) antigen in alloimmunized pregnancies, reported as selected antigen(s) detected or not detected   | Effective 10/1/2024   |

| CPT, HCPCS<br>or Revenue Code   | LAB Description   | Comments/ Limitations |
|---|---|-----------------------|
| <b>All genetic testing codes require review and preauthorization.</b> |   |                       |
| 0494U   | Red blood cell antigen (fetal RhD gene analysis), next-generation sequencing of circulating cell-free DNA (cfDNA) of blood in pregnant individuals known to be RhD negative, reported as positive or negative | Effective 10/1/2024   |
| S3840   | DNA analysis for germline mutations of the RET proto-oncogene for susceptibility to multiple endocrine neoplasia type 2   |                       |
| S3841   | Genetic testing for retinoblastoma  |                       |
| S3842   | Genetic testing for von Hippel-Lindau disease   |                       |
| S3844   | DNA analysis of the connexin 26 gene (GJB2) for susceptibility to congenital, profound deafness   |                       |
| S3845   | Genetic testing for alpha-thalassemia   |                       |
| S3846   | Genetic testing for hemoglobin E beta-thalassemia   |                       |
| S3849   | Genetic testing for Niemann-Pick Disease  |                       |
| S3850   | Genetic testing for sickle cell anemia  |                       |
| S3853   | Genetic testing for myotonic muscular dystrophy   |                       |
| S3866   | Genetic analysis for a specific gene mutation for hypertrophic cardiomyopathy (HCM) in an individual with a known HCM mutation in the family  |                       |

| HCPCS Code | DME Description   | Comments/ Limitations                   |
|------------|---|---|
| A6521      | Gradient compression garment, glove, padded, for nighttime use, custom, each              | Effective 1/1/24 (Added on 5/1/24 list) |
| A6523      | Gradient compression garment, arm, padded, for nighttime use, custom, each                | Effective 1/1/24 (Added on 5/1/24 list) |
| A6525      | Gradient compression garment, lower leg and foot, padded, for nighttime use, custom, each | Effective 1/1/24 (Added on 5/1/24 list) |
| A6527      | Gradient compression garment, full leg and foot, padded, for nighttime use, custom, each  | Effective 1/1/24 (Added on 5/1/24 list) |
| A6529      | Gradient compression garment, bra, for nighttime use, custom, each                        | Effective 1/1/24 (Added on 5/1/24 list) |
| A6555      | Gradient compression stocking, below knee, 40 mmhg or greater, custom, each               | Effective 1/1/24 (Added on 5/1/24 list) |
| A6556      | Gradient compression stocking, thigh length, 18-30 mmhg, custom, each                     | Effective 1/1/24 (Added on 5/1/24 list) |
| A6557      | Gradient compression stocking, thigh length, 30-40 mmhg, custom, each                     | Effective 1/1/24 (Added on 5/1/24 list) |
| A6558      | Gradient compression stocking, thigh length, 40 mmhg or greater, custom, each             | Effective 1/1/24 (Added on 5/1/24 list) |
| A6559      | Gradient compression stocking, full length/chap style, 18-30 mmhg, custom, each           | Effective 1/1/24 (Added on 5/1/24 list) |
| A6560      | Gradient compression stocking, full length/chap style, 30-40 mmhg, custom, each           | Effective 1/1/24 (Added on 5/1/24 list) |
| A6561      | Gradient compression stocking, full length/chap style, 40 mmhg or greater, custom, each   | Effective 1/1/24 (Added on 5/1/24 list) |
| A6562      | Gradient compression stocking, waist length, 18-30 mmhg, custom, each                     | Effective 1/1/24 (Added on 5/1/24 list) |
| A6563      | Gradient compression stocking, waist length, 30-40 mmhg, custom, each                     | Effective 1/1/24 (Added on 5/1/24 list) |
| A6564      | Gradient compression stocking, waist length, 40 mmhg or greater, custom, each             | Effective 1/1/24 (Added on 5/1/24 list) |

| HCPCS Code | DME Description  | Comments/ Limitations                         |
|------------|--|---|
| A6565      | Gradient compression gauntlet, custom, each  | Effective 1/1/24 (Added on 5/1/24 list)       |
| A6567      | Gradient compression garment, neck/head, custom, each                                      | Effective 1/1/24 (Added on 5/1/24 list)       |
| A6569      | Gradient compression garment, torso/shoulder, custom, each                                 | Effective 1/1/24 (Added on 5/1/24 list)       |
| A6571      | Gradient compression garment, genital region, custom, each                                 | Effective 1/1/24 (Added on 5/1/24 list)       |
| A6573      | Gradient compression garment, toe caps, custom, each                                       | Effective 1/1/24 (Added on 5/1/24 list)       |
| A6574      | Gradient compression arm sleeve and glove combination, custom, each                        | Effective 1/1/24 (Added on 5/1/24 list)       |
| A6576      | Gradient compression arm sleeve, custom, medium weight, each                               | Effective 1/1/24 (Added on 5/1/24 list)       |
| A6577      | Gradient compression arm sleeve, custom, heavy weight, each                                | Effective 1/1/24 (Added on 5/1/24 list)       |
| A6579      | Gradient compression glove, custom, medium weight, each                                    | Effective 1/1/24 (Added on 5/1/24 list)       |
| A6580      | Gradient compression glove, custom, heavy weight, each                                     | Effective 1/1/24 (Added on 5/1/24 list)       |
| A7021      | Supplies and accessories for lung expansion airway clearance, continuous high frequency    | Effective 10/1/24                             |
| A9276      | Senseonics Eversense E3 Sensor Kit   | <a href="#">Effective 1/1/25. Reviewed by</a> |
| B4105      | Digestive enzyme cartridge   | Effective 9/1/2022                            |
| C1767      | Generator, neurostimulator (implantable), non-rechargeable                                 | Effective 1/1/25                              |
| C1778      | Lead, neurostimulator (implantable)  | Effective 1/1/25                              |
| C1787      | Patient programmer, neurostimulator  | Effective 1/1/25                              |
| C1816      | Receiver and/or transmitter, neurostimulator (implantable)                                 | Effective 1/1/25                              |
| C1820      | Generator, neurostimulator (implantable), with rechargeable battery and charging system.   | Effective 1/1/25                              |
| C1822      | Generator, neurostimulator (implantable), high frequency, with rechargeable battery and    | Effective 1/1/25                              |
| C1831      | Custom cage for spine  | Effective 1/1/2022                            |
| C1832      | Autograft suspension, including cell processing and application, and all system components | Effective 9/1/2022                            |
| C1833      | Monitor, cardiac, including intracardiac lead and all system components (implantable)      | Effective 9/1/2022                            |
| C1883      | Adaptor/extension, pacing lead or neurostimulator lead (implantable)                       | Effective 1/1/25                              |

| HCPCS Code | DME Description   | Comments/ Limitations      |
|------------|---|----------------------------|
| C1897      | Lead, neurostimulator test kit (implantable)  | Effective 1/1/25           |
| C9781      | Arthroscopy, shoulder, surgical; with implantation of subacromial spacer (e.g., balloon),     | Effective 9/1/2022         |
| E0194      | Air fluidized bed   |                            |
| E0277      | Powered -pressure reducing air mattress   | Effective 9/1/2020         |
| E0465      | Home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube)            |                            |
| E0466      | Home ventilator, any type, used with non-invasive interface, (e.g., mask, chest shell)        |                            |
| E0467      | Home ventilator, multi-function respiratory device  | Effective 8/1/24           |
| E0468      | Home ventilator, dual-function respiratory device, also performs additional function of cough | Effective 4/1/24 (added on |
| E0469      | Lung expansion airway clearance, continuous high frequency oscillation, and nebulization      | Effective 10/1/24          |
| E0482      | Cough stimulating device, alternating positive and negative airway pressure E0482.            | Effective 8/1/24           |
| E0483      | High frequency chest wall oscillation system, includes all accessories and supplies, each     |                            |
| E0486      | Oral device used to reduce upper airway   | Effective 9/1/2020         |
| E0630      | Patient Lift - Hydraulic  | Effective 9/1/2020         |
| E0638      | Standing frame/table system one position  | Effective 9/1/2020         |
| E0652      | Pneumatic compressor, segmental home model with calibrated gradient pressure                  |                            |
| E0658      | Segmental pneumatic appliance for use with pneumatic compressor, integrated, 2 full arms      | Effective 5/1/2026         |
| E0659      | Segmental pneumatic appliance for use with pneumatic compressor, integrated, head, neck       | Effective 5/1/2026         |
| E0670      | Segmental pneumatic appliance for use with pneumatic compressor, integrated, 2 full legs      |                            |
| E0683      | Non-pneumatic, non-sequential, peristaltic wave compression pump                              | Effective 10/1/24          |
| E0747      | Osteogenesis stimulator, electrical, non-invasive, other than spinal applications             |                            |
| E0748      | Osteogenesis stimulator, electrical, non-invasive, spinal applications                        |                            |
| E0760      | osteogenesis stimulator, low intensity ultrasound, non-invasive                               |                            |
| E0764      | Functional neuromuscular stimulation, transcutaneous stimulation of sequential muscle         |                            |
| E0765      | Fda approved nerve stimulator, for treatment of nausea and vomiting                           | Effective 5/1/2026         |
| E0766      | electrical stimulation device for cancer treatment  | Effective 5/19/2020        |

| HCPCS Code | DME Description   | Comments/ Limitations |
|------------|---|-----------------------|
| E0767      | Intrabuccal, systemic delivery of amplitude-modulated, radiofrequency electromagnetic field | Effective 10/1/24     |
| E0782      | Infusion pump, implantable, non-programmable (includes all components, e.g., pump,          |                       |
| E0783      | Infusion pump system, implantable, programmable (includes all components, e.g., pump,       |                       |
| E0786      | Implantable programmable infusion pump, replacement (excludes implantable intraspinal       |                       |
| E0986      | Manual wheelchair accessory, power assist system  | Effective 9/1/2020    |
| E1002      | Wheelchair accessory, power seating system  | Effective 9/1/2020    |
| E1007      | Wheelchair accessory, power seating system  | Effective 9/1/2020    |
| E1220      | Wheelchair, special size or construction  | Effective 9/1/2020    |
| E1230      | Power operated vehicle (three or four wheel non highway) specify brand name and model       |                       |
| E1232      | Wheelchair, pediatric size, tilt in space, folding  | Effective 9/1/2020    |
| E1234      | Wheelchair, pediatric size,   | Effective 9/1/2020    |
| E1235      | Wheelchair, pediatric size  | Effective 9/1/2020    |
| E1236      | Wheelchair pediatric size   | Effective 9/1/2020    |
| E2311      | Power wheelchair accessory  | Effective 9/1/2020    |
| E2368      | Power wheelchair component, motor, replacement only   |                       |
| E2369      | Power wheelchair component, gearbox, replacement only                                       |                       |
| E2370      | Power wheelchair component, motor and gearbox combination, replacement only                 |                       |
| E2502      | Speech generating device, digitized speech, using pre-recorded messages, greater than 8     |                       |
| E2504      | Speech generating device, digitized speech, using pre-recorded messages, greater than 20    |                       |
| E2506      | Speech generating device, digitized speech, using pre-recorded messages, greater than 40    |                       |
| E2508      | Speech generating device, synthesized speech, requiring message formulation by spelling and |                       |
| E2510      | Speech generating device, synthesized speech, permitting multiple methods of message        |                       |
| E2513      | Accessory for speech generating device, electromyographic sensor                            | Effective 10/1/24     |
| E2609      | Custom fabricated wheelchair seat cushion   | Effective 9/1/2020    |
| E2627      | Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair,            |                       |

| HCPCS Code | DME Description  | Comments/ Limitations |
|------------|--|-----------------------|
| E2629      | Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair,             |                       |
| E3200      | Gait modulation system, rhythmic auditory stimulation, including restricted therapy          | Effective 10/1/24     |
| K0005      | Ultra Lightweight wheelchair   |                       |
| K0006      | Heavy-duty wheelchair  |                       |
| K0009      | Other manual wheelchair/base   | Effective 9/1/2020    |
| K0606      | Automatic external defibrillator, with integrated electrocardiogram analysis, garment type   |                       |
| K0609      | Replacement electrodes for use with automated external defibrillator, garment type only,     |                       |
| K0800      | Power operated vehicle, group 1 standard, patient weight capacity up to and including 300    |                       |
| K0801      | Power operated vehicle, group 1 heavy duty, patient weight capacity, 301 to 450 pounds       |                       |
| K0802      | Power operated vehicle, group 1 heavy duty, patient weight capacity 451 to 600 pounds        |                       |
| K0806      | Powered operated vehicle, group 2 standard, patient weight capacity up to and including 300  |                       |
| K0807      | K0807: Power operated vehicle, group 2 heavy duty, patient weight capacity 301 to 450        |                       |
| K0808      | K0808: Power operated vehicle, group 2 very heavy duty, patient weight capacity 451 to 600   |                       |
| K0812      | Power operated vehicle, not otherwise classified   |                       |
| K0813      | Power wheelchair, group 1 standard, portable, sling/solid seat and back, patient weight      |                       |
| K0814      | Power wheelchair, group 1 standard, portable, captain's chair, patient weight capacity up to |                       |
| K0815      | Power wheelchair, group 1 standard, portable, sling/solid seat and back, patient weight      |                       |
| K0816      | Power wheelchair, group 1 standard, captain's chair, patient weight capacity up to and       |                       |
| K0820      | Power wheelchair, group 2 standard, portable, sling/solid seat/back, patient weight capacity |                       |
| K0821      | Power wheelchair, group 2 standard, portable, captain's chair, patient weight capacity up to |                       |
| K0822      | Power wheelchair, group 2 standard, sling/solid seat/back, patient weight capacity up to and |                       |
| K0823      | Power wheelchair, group 2 standard, captain's chair, patient weight capacity up to and       |                       |
| K0824      | Power wheelchair, group 2 heavy duty, sling/solid seat and back, patient weight capacity 301 |                       |
| K0825      | Power wheelchair, group 2 heavy duty, captain's chair, patient weight capacity 301 to 450    |                       |
| K0826      | Power wheelchair, group 2 very heavy duty, sling/solid seat/back, patient weight capacity    |                       |

| HCPCS Code | DME Description  | Comments/ Limitations |
|------------|--|-----------------------|
| K0827      | Power wheelchair, group 2 very heavy duty, captain's chair, patient weight capacity 451 to   |                       |
| K0828      | Power wheelchair, group 2 extra very heavy duty, sling/solid seat/back, patient weight       |                       |
| K0829      | Power wheelchair, group 2 extra heavy duty, captain's chair, patient weight capacity 601     |                       |
| K0835      | Power wheelchair, group 2 standard, single power option, sling/solid seat/back, patient      |                       |
| K0836      | Power wheelchair, group 2 standard, single power option, captain's chair, patient weight     |                       |
| K0837      | Power wheelchair, group 2 heavy duty, single power option, sling/solid seat/back, patient    |                       |
| K0838      | Power wheelchair, group 2 heavy duty, single power option, captain's chair, patient weight   |                       |
| K0839      | Power wheelchair, group 2 very heavy duty, single power option, sling/solid seat/back,       |                       |
| K0840      | Power wheelchair, group 2 very heavy duty, single power option, sling/solid seat/back,       |                       |
| K0841      | Power wheelchair, group 2 standard, multiple power option, sling/solid seat/back, patient    |                       |
| K0842      | Power wheelchair, group 2 standard, multiple power option, captain's chair, patient weight   |                       |
| K0843      | Power wheelchair, group 2 heavy duty, multiple power option, sling/solid seat/back, patient  |                       |
| K0848      | Power wheelchair, group 3 standard, sling/solid seat/back, patient weight capacity up to and |                       |
| K0849      | Power wheelchair, group 3 standard, captain's chair, patient weight capacity up to and       |                       |
| K0850      | Power wheelchair, group 3 heavy duty, sling/solid seat/back, patient weight capacity 301 to  |                       |
| K0851      | Power wheelchair, group 3 heavy duty, captain's chair, patient weight capacity 301 to 450    |                       |
| K0852      | Power wheelchair, group 3 very heavy duty, sling/solid seat/back, patient weight capacity    |                       |
| K0853      | Power wheelchair, group 3 very heavy duty, captains chair, patient weight capacity 451 to    |                       |
| K0854      | Power wheelchair, group 3 extra heavy duty, sling/solid seat/back, patient weight capacity   |                       |
| K0855      | Power wheelchair, group 3 extra heavy duty, captains chair, patient weight capacity 601      |                       |
| K0856      | Power wheelchair, group 3 standard, single power option, sling/solid seat/back, patient      |                       |
| K0857      | Power wheelchair, group 3 standard, single power option, captain's chair, patient weight     |                       |
| K0858      | Power wheelchair, group 3 heavy duty, single power option, sling/solid seat/back, patient    |                       |
| K0859      | Power wheelchair, group 3 heavy duty, single power option, captain's chair, patient weight   |                       |
| K0860      | Power wheelchair, group 3 very heavy duty, single power option, sling/solid seat/back,       |                       |

| HCPCS Code | DME Description  | Comments/ Limitations |
|------------|--|-----------------------|
| K0861      | Power wheelchair, group 3 standard, multiple power option, sling/solid seat/back, patient        |                       |
| K0862      | Power wheelchair, group 3 heavy duty, multiple power option, sling/solid seat/back, patient      |                       |
| K0863      | Power wheelchair, group 3 very heavy duty, multiple power option, sling/solid seat/back,         |                       |
| K0864      | Power wheelchair, group 3 extra heavy duty, multiple power option, sling/solid seat/back,        |                       |
| K0868      | Power wheelchair, group 4 standard, sling/solid seat/back, patient weight capacity up to and     |                       |
| K0869      | Power wheelchair, group 4 standard, captain's chair, patient weight capacity up to and           |                       |
| K0870      | Power wheelchair, group 4 heavy duty, sling/solid seat/back, patient weight capacity 301 to      |                       |
| K0871      | Power wheelchair, group 4 very heavy duty, sling/solid seat/back, patient weight capacity        |                       |
| K0877      | Power wheelchair, group 4 standard, single power option, sling/solid seat/back, patient          |                       |
| K0878      | Power wheelchair, group 4 standard, single power option, captain's chair, patient weight         |                       |
| K0879      | Power wheelchair, group 4 heavy duty, single power option, sling/solid seat/back, patient        |                       |
| K0880      | Power wheelchair, group 4 very heavy duty, single power option, sling/solid seat/back,           |                       |
| K0884      | Power wheelchair, group 4 standard, multiple power option, sling/solid seat/back, patient        |                       |
| K0885      | Power wheelchair, group 4 standard, multiple power option, captain's chair, patient weight       |                       |
| K0886      | Power wheelchair, group 4 heavy duty, multiple power option, sling/solid seat/back, patient      |                       |
| K0890      | Power wheelchair, group 5 pediatric, single power option, sling/solid seat/back, patient         |                       |
| K0891      | Power wheelchair, group 5 pediatric, multiple power option, sling/solid seat/back, patient       |                       |
| K0898      | Power wheelchair, not otherwise classified   |                       |
| K0899      | Power mobility device, not coded by DME PDAC or does not meet criteria                           |                       |
| L0112      | Cranial cervical orthosis, congenital torticollis type, with or without soft interface material, |                       |
| L0456      | Thoracic-lumbar-sacral orthosis (TLSO), flexible, provides trunk support, thoracic region, rigid |                       |
| L0457      | Thoracic-lumbar-sacral orthosis (TLSO), flexible, provides trunk support, thoracic region, rigid |                       |
| L0458      | Thoracic-lumbar-sacral orthosis (TLSO), triplanar control, modular segmented spinal system,      |                       |
| L0460      | Thoracic-lumbar-sacral orthosis (TLSO), triplanar control, modular segmented spinal system,      |                       |
| L0462      | Thoracic-lumbar-sacral orthosis (TLSO), triplanar control, modular segmented spinal system,      |                       |

| HCPCS Code | DME Description   | Comments/ Limitations |
|------------|---|-----------------------|
| L0464      | Thoracic-lumbar-sacral orthosis (TLSO), triplanar control, modular segmented spinal system,   |                       |
| L0480      | Thoracic-lumbar-sacral orthosis (TLSO), triplanar control, one piece rigid plastic shell without  |                       |
| L0482      | Thoracic-lumbar-sacral orthosis (TLSO), triplanar control, one piece rigid plastic shell with   |                       |
| L0484      | Thoracic-lumbar-sacral orthosis (TLSO), triplanar control, two piece rigid plastic shell without  |                       |
| L0486      | Thoracic-lumbar-sacral orthosis (TLSO), triplanar control, two piece rigid plastic shell with   |                       |
| L0488      | Thoracic-lumbar-sacral orthosis (TLSO), triplanar control, one piece rigid plastic shell with   |                       |
| L0631      | Lumbar-sacral orthosis (LSO), sagittal control, with rigid anterior and posterior panels,   |                       |
| L0635      | Lumbar-sacral orthosis (LSO), sagittal-coronal control, lumbar flexion, rigid posterior   |                       |
| L0636      | Lumbar-sacral orthosis (LSO), sagittal-coronal control, lumbar flexion, rigid posterior   |                       |
| L0637      | Lumbar-sacral orthosis (LSO), sagittal-coronal control, with rigid anterior and posterior   |                       |
| L0638      | Lumbar-sacral orthosis (LSO), sagittal-coronal control, with rigid anterior and posterior   |                       |
| L0639      | Lumbar-sacral orthosis (LSO), sagittal-coronal control, rigid shell(s)/panel(s), posterior  |                       |
| L0640      | Lumbar-sacral orthosis (LSO), sagittal-coronal control, rigid shell(s)/panel(s), posterior  |                       |
| L0648      | Lumbar-sacral orthosis (LSO), sagittal control, with rigid anterior and posterior panels,   |                       |
| L0650      | Lumbar-sacral orthosis (LSO), sagittal-coronal control, with rigid anterior and posterior   |                       |
| L0651      | Lumbar-sacral orthosis (LSO), sagittal-coronal control, rigid shell(s)/panel(s), posterior  |                       |
| L0700      | Cervical-thoracic-lumbar-sacral-orthoses (CTLSO), anterior-posterior-lateral control, molded  |                       |
| L0710      | Cervical-thoracic-lumbar-sacral-orthoses (CTLSO), anterior-posterior-lateral-control, molded  |                       |
| L0720      | Cervical-thoracic-lumbar-sacral-orthoses (ctlso), anterior-posterior-lateral control,   | Effective 4/1/25      |
| L1000      | Cervical-thoracic-lumbar-sacral orthosis (CTLSO) (Milwaukee), inclusive of furnishing initial   |                       |
| L1005      | Tension based scoliosis orthosis and accessory pads, includes fitting and adjustment  |                       |
| L1007      | Scoliosis orthosis, sagittal-coronal control provided by a rigid lateral frame, extends from axilla, to trochanter, includes all accessory pads, straps, and interface, custom fabricated | Effective 1/1/2026    |
| L1200      | Thoracic-lumbar-sacral-orthosis (TLSO), inclusive of furnishing initial orthosis only   |                       |
| L1300      | Other scoliosis procedure, body jacket molded to patient model  |                       |

| HCPCS Code | DME Description   | Comments/ Limitations |
|------------|---|-----------------------|
| L1310      | Other scoliosis procedure, postoperative body jacket  |                       |
| L1680      | Hip orthosis (HO), abduction control of hip joints, dynamic, pelvic control, adjustable hip       |                       |
| L1681      | Hip orthosis (HO), bilateral hip joints and thigh cuffs, adjustable flexion, extension, abduction | Effective 1/1/24      |
| L1685      | Hip orthosis (HO), abduction control of hip joint, postoperative hip abduction type, custom       |                       |
| L1686      | Hip orthosis (HO), abduction control of hip joint, postoperative hip abduction type,              |                       |
| L1690      | Combination, bilateral, lumbo-sacral, hip, femur orthosis providing adduction and internal        |                       |
| L1700      | Legg-perthes orthosis, (Toronto type), custom-fabricated  |                       |
| L1710      | Legg-perthes orthosis, (Newington type), custom fabricated  |                       |
| L1720      | Legg-perthes orthosis, trilateral, (Tachdijan type), custom-fabricated                            |                       |
| L1730      | Legg-perthes orthosis, (Scottish Rite type), custom-fabricated                                    |                       |
| L1755      | Legg-perthes orthosis, (Patten bottom type), custom-fabricated                                    |                       |
| L1834      | Knee orthosis, without knee joint, rigid, custom-fabricated                                       |                       |
| L1840      | Knee orthosis (KO), derotation, medial-lateral, anterior cruciate ligament, custom fabricated     |                       |
| L1843      | Knee orthosis (KO), single upright, thigh and calf, with adjustable flexion and extension joint   |                       |
| L1844      | Knee orthosis (KO), single upright, thigh and calf, with adjustable flexion and extension joint   |                       |
| L1845      | Knee orthosis (KO), double upright, thigh and calf, with adjustable flexion and extension joint   |                       |
| L1846      | Knee orthosis (KO), double upright, thigh and calf, with adjustable flexion and extension joint   |                       |
| L1851      | Knee orthosis (ko), single upright, thigh and calf, with adjustable flexion and extension joint   |                       |
| L1852      | Knee orthosis (ko), double upright, thigh and calf, with adjustable flexion and extension joint   |                       |
| L1860      | Knee orthosis (KO), modification of supracondylar prosthetic socket, custom-fabricated (SK)       |                       |
| L1920      | Ankle foot orthosis, single upright with static or adjustable stop (Phelps or Perlstein type),    |                       |
| L1930      | prefabricated - Ankle foot orthosis, plastic or other material, prefabricated, includes fitting   |                       |
| L1932      | Ankle foot orthosis (AFO), rigid anterior tibial section, total carbon fiber or equal material,   |                       |
| L1940      | Ankle foot orthosis, plastic or other material, custom-fabricated                                 |                       |
| L1945      | Ankle foot orthosis (AFO), plastic, rigid anterior tibial section (floor reaction), custom-       |                       |

| HCPCS Code | DME Description  | Comments/ Limitations |
|------------|--|-----------------------|
| L1950      | Ankle foot orthosis, spiral, (institute of rehabilitative medicine type), plastic, custom-       |                       |
| L1951      | Ankle foot orthosis, spiral, (Institute of Rehabilitative Medicine type), plastic or other       |                       |
| L1960      | Ankle foot orthosis, posterior solid ankle, plastic, custom-fabricated                           |                       |
| L1970      | Ankle foot orthosis, plastic with ankle joint, custom-fabricated                                 |                       |
| L1971      | Ankle foot orthosis, single upright free plantar dorsiflexion, solid stirrup, calf band/cuff     |                       |
| L1980      | Ankle foot orthosis, double upright free plantar dorsiflexion, solid stirrup, calf band/cuff     |                       |
| L1990      | Knee ankle foot orthosis, single upright, free knee, free ankle, solid stirrup, thigh and calf   |                       |
| L2000      | Knee ankle foot orthosis (KAFO), single upright, free knee, free ankle, solid stirrup, thigh and |                       |
| L2005      | Knee ankle foot orthosis (KAFO), any material, single or double upright, stance control,         |                       |
| L2010      | Knee ankle foot orthosis (KAFO), single upright, free ankle, solid stirrup, thigh and calf       |                       |
| L2020      | Knee ankle foot orthosis (KAFO), double upright, free ankle, solid stirrup, thigh and calf       |                       |
| L2030      | Knee ankle foot orthosis (KAFO), double upright, free ankle, solid stirrup, thigh and calf       |                       |
| L2034      | Knee ankle foot orthosis (KAFO), full plastic, single upright, with or without free motion knee, |                       |
| L2035      | Knee ankle foot orthosis, full plastic, static (pediatric size), without free motion ankle,      |                       |
| L2036      | Knee ankle foot orthosis, full plastic, double upright, with or without free motion knee, with   |                       |
| L2037      | Knee ankle foot orthosis (KAFO), full plastic, single upright, with or without free motion knee, |                       |
| L2038      | Knee ankle foot orthosis (KAFO), full plastic, with or without free motion knee, multi-axis      |                       |
| L2108      | Ankle foot orthosis (AFO), fracture orthosis, tibial fracture cast orthosis, custom-fabricated   |                       |
| L2126      | Knee ankle foot orthosis (KAFO), fracture orthosis, femoral fracture cast orthosis,              |                       |
| L2128      | Knee ankle foot orthosis(KAFO), fracture orthosis, femoral fracture cast orthosis, custom-       |                       |
| L2134      | Knee ankle foot orthosis(KAFO), fracture orthosis, femoral fracture cast orthosis, semi-rigid,   |                       |
| L2136      | Knee ankle foot orthosis(KAFO), fracture orthosis, femoral fracture cast orthosis, rigid,        |                       |
| L2232      | Addition to lower extremity orthosis, rocker bottom for total contact ankle foot orthosis, for   |                       |
| L2320      | Addition to lower extremity, non-molded lacer, for custom fabricated orthosis only               |                       |
| L2330      | Addition to lower extremity, lacer molded to patient model, for custom fabricated orthosis       |                       |

| HCPCS Code | DME Description   | Comments/ Limitations |
|------------|---|-----------------------|
| L2350      | Addition to lower extremity, prosthetic type, (BK) socket, molded to patient model, (used for     |                       |
| L2387      | Addition to lower extremity, polycentric knee joint, for custom fabricated knee ankle foot        |                       |
| L2520      | Addition to lower extremity, thigh/weight bearing, quadrilateral brim, custom fitted              |                       |
| L2525      | Addition to lower extremity, thigh/weight bearing, ischial containment/narrow M-L brim            |                       |
| L2627      | Addition to lower extremity, pelvic control, plastic, molded to patient model, reciprocating      |                       |
| L2628      | Addition to lower extremity, pelvic control, metal frame, reciprocating hip joint and cables      |                       |
| L2800      | Addition to lower extremity orthosis, knee control, knee cap, medial or lateral pull, for use     |                       |
| L4000      | Replace girdle for spinal orthosis (Cervical-thoracic-lumbar-sacral orthosis (CTLSSO) or          |                       |
| L4020      | Replace quadrilateral socket brim, molded to patient model  |                       |
| L4631      | Ankle foot orthosis (AFO), walking boot type, varus/valgus correction, rocker bottom,             |                       |
| L5010      | Partial foot, molded socket, ankle height, with toe filler  |                       |
| L5020      | Partial foot, molded socket, tibial tubercle height, with toe filler                              |                       |
| L5050      | Ankle, Symes, molded socket, SACH foot  |                       |
| L5060      | Ankle, Symes, metal frame, molded leather socket, articulated ankle/foot                          |                       |
| L5100      | Below knee, molded socket, shin, SACH foot  |                       |
| L5105      | Below knee, plastic socket, joints and thigh lacer, SACH foot                                     |                       |
| L5150      | Knee disarticulation (or through knee), molded socket, external knee joints, shin, SACH foot      |                       |
| L5160      | Knee disarticulation (or through knee), molded socket, bent knee configuration, external          |                       |
| L5200      | Above knee, molded socket, single axis constant friction knee, shin, SACH foot                    |                       |
| L5210      | Above knee, short prosthesis, no knee joint ('stubbies'), with foot blocks, no ankle joints,      |                       |
| L5220      | Above knee, short prosthesis, no knee joint ('stubbies'), with articulated ankle/foot,            |                       |
| L5230      | Above knee, for proximal femoral focal deficiency, constant friction knee, shin, SACH foot        |                       |
| L5250      | Hip disarticulation, Canadian type; molded socket, hip joint, single axis constant friction knee, |                       |
| L5270      | Hip disarticulation, tilt table type; molded socket, locking hip joint, single axis constant      |                       |
| L5280      | Hemipelvectomy, Canadian type; molded socket, hip joint, single axis constant friction knee,      |                       |

| HCPCS Code | DME Description   | Comments/ Limitations |
|------------|---|-----------------------|
| L5301      | Below knee, molded socket, shin, SACH foot, endoskeletal system                                     |                       |
| L5312      | Knee disarticulation (or through knee), molded socket, single axis knee, pylon, SACH foot,          |                       |
| L5321      | Above knee, molded socket, open end, SACH foot, endoskeletal system, single axis knee               |                       |
| L5331      | Hip disarticulation, Canadian type, molded socket, endoskeletal system, hip joint, single axis      |                       |
| L5341      | Hemipelvectomy, Canadian type, molded socket, endoskeletal system, hip joint, single axis           |                       |
| L5400      | Immediate post surgical or early fitting, application of initial rigid dressing, including fitting, |                       |
| L5420      | Immediate post surgical or early fitting, application of initial rigid dressing, including fitting, |                       |
| L5500      | Initial, below knee 'PTB' type socket, non-alignable system, pylon, no cover, SACH foot,            |                       |
| L5505      | Initial, above knee - knee disarticulation, ischial level socket, non-alignable system, pylon, no   |                       |
| L5510      | Preparatory, below knee 'PTB' type socket, non-alignable system, pylon, no cover, SACH foot,        |                       |
| L5520      | Preparatory, below knee 'PTB' type socket, non-alignable system, pylon, no cover, SACH foot,        |                       |
| L5530      | Preparatory, below knee 'PTB' type socket, non-alignable system, pylon, no cover, SACH foot,        |                       |
| L5535      | Preparatory, below knee 'PTB' type socket, non-alignable system, no cover, SACH foot,               |                       |
| L5540      | Preparatory, below knee 'PTB' type socket, non-alignable system, pylon, no cover, SACH foot,        |                       |
| L5560      | Preparatory, above knee- knee disarticulation, ischial level socket, non-alignable system,          |                       |
| L5570      | Preparatory, above knee - knee disarticulation, ischial level socket, non-alignable system,         |                       |
| L5580      | Preparatory, above knee - knee disarticulation ischial level socket, non-alignable system,          |                       |
| L5585      | Preparatory, above knee - knee disarticulation, ischial level socket, non-alignable system,         |                       |
| L5590      | Preparatory, above knee - knee disarticulation ischial level socket, non-alignable system,          |                       |
| L5595      | Preparatory, hip disarticulation-hemipelvectomy, pylon, no cover, SACH foot, thermoplastic          |                       |
| L5600      | Preparatory, hip disarticulation-hemipelvectomy, pylon, no cover, SACH foot, laminated              |                       |
| L5610      | Addition to lower extremity, endoskeletal system, above knee, hydracadence system                   |                       |
| L5611      | Addition to lower extremity, endoskeletal system, above knee-knee disarticulation, 4 bar            |                       |
| L5613      | Addition to lower extremity, endoskeletal system, above knee-knee disarticulation, 4 bar            |                       |
| L5614      | Addition to lower extremity, exoskeletal system, above knee-knee disarticulation, 4 bar             |                       |

| HCPCS Code | DME Description  | Comments/ Limitations      |
|------------|--|----------------------------|
| L5615      | Addition, endoskeletal knee-shin system, 4 bar linkage or multiaxial, fluid swing and stance   | Effective 1/1/24 (Added on |
| L5616      | Addition to lower extremity, endoskeletal system, above knee, universal multiplex system,  |                            |
| L5639      | Addition to lower extremity, below knee, wood socket   |                            |
| L5643      | Addition to lower extremity, hip disarticulation, flexible inner socket, external frame  |                            |
| L5645      | Addition to lower extremity, below knee, flexible inner socket, external frame   |                            |
| L5647      | Addition to lower extremity, below knee suction socket   |                            |
| L5649      | Addition to lower extremity, ischial containment/narrow M-L socket   |                            |
| L5651      | Addition to lower extremity, above knee, flexible inner socket, external frame   |                            |
| L5657      | Addition to lower extremity prosthesis, manual/automated adjustable air, fluid, gel or equal   | Effective 1/1/2026         |
| L5673      | Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric, or equal, with or without perforations, with or without breathable material, for use with locking mechanism     | Effective 5/1/2026         |
| L5679      | Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric, or equal, with or without perforations, with or without breathable material, not for use with locking mechanism | Effective 5/1/2026         |
| L5681      | Addition to lower extremity, below knee/above knee, custom fabricated socket insert for  |                            |
| L5683      | Addition to lower extremity, below knee/above knee, custom fabricated socket insert for  |                            |
| L5700      | Replacement, socket, below knee, molded to patient model   |                            |
| L5701      | Replacement, socket, above knee/knee disarticulation, including attachment plate, molded   |                            |
| L5702      | Replacement, socket, hip disarticulation, including hip joint, molded to patient model   |                            |
| L5703      | Ankle, Symes, molded to patient model, socket without solid ankle cushion heel (SACH) foot,  |                            |
| L5705      | Custom shaped protective cover, above knee   |                            |
| L5706      | Custom shaped protective cover, knee disarticulation   |                            |
| L5707      | Custom shaped protective cover, hip disarticulation  |                            |
| L5718      | Addition, exoskeletal knee-shin system, polycentric, friction swing and stance phase control   |                            |
| L5722      | Addition, exoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase  |                            |

| HCPCS Code | DME Description   | Comments/ Limitations |
|------------|---|-----------------------|
| L5724      | Addition, exoskeletal knee-shin system, single axis, fluid swing phase control  |                       |
| L5726      | Addition, exoskeletal knee-shin system, single axis, external joints fluid swing phase control                                    |                       |
| L5728      | Addition, exoskeletal knee-shin system, single axis, fluid swing and stance phase control   |                       |
| L5780      | Addition, exoskeletal knee-shin system, single axis, pneumatic/hydra pneumatic swing phase  |                       |
| L5781      | Addition to lower limb prosthesis, vacuum pump, residual limb volume management and   |                       |
| L5782      | Addition to lower limb prosthesis, vacuum pump, residual limb volume management and   |                       |
| L5783      | Addition to lower extremity, user adjustable, mechanical, residual limb volume management system (with or without lamination kit) | Effective 5/1/2026    |
| L5795      | Addition, exoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber                                   |                       |
| L5814      | Addition, endoskeletal knee-shin system, polycentric, hydraulic swing phase control,  |                       |
| L5816      | Addition, endoskeletal knee-shin system, polycentric, mechanical stance phase lock  |                       |
| L5818      | Addition, endoskeletal knee-shin system, polycentric, friction swing, and stance phase  |                       |
| L5822      | Addition, endoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase                                      |                       |
| L5824      | Addition, endoskeletal knee-shin system, single axis, fluid swing phase control   |                       |
| L5826      | Addition, endoskeletal knee-shin system, single axis, hydraulic swing phase control, with   |                       |
| L5827      | Endoskeletal knee-shin system, single axis, electromechanical swing and stance phase  | Effective 4/1/25      |
| L5828      | Addition, endoskeletal knee-shin system, single axis, fluid swing and stance phase control  |                       |
| L5830      | Addition, endoskeletal knee-shin system, single axis, pneumatic/ swing phase control  |                       |
| L5840      | Addition, endoskeletal knee/shin system, 4-bar linkage or multiaxial, pneumatic swing phase                                       |                       |
| L5845      | Addition, endoskeletal, knee-shin system, stance flexion feature, adjustable  |                       |
| L5848      | Addition to endoskeletal knee-shin system, fluidstance extension, dampening feature, with   |                       |
| L5856      | Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor   |                       |
| L5857      | Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor   |                       |
| L5858      | Addition to lower extremity prosthesis, endoskeletal knee shin system, microprocessor   |                       |
| L5859      | Addition to lower extremity prosthesis, endoskeletal knee-shin system, powered and  |                       |

| HCPCS Code | DME Description   | Comments/ Limitations      |
|------------|---|----------------------------|
| L5926      | Addition to lower extremity prosthesis, endoskeletal, knee disarticulation, above knee, hip   | Effective 1/1/24 (Added on |
| L5930      | Addition, endoskeletal system, high activity knee control frame   |                            |
| L5950      | Addition, endoskeletal system, above knee, ultra-light material (titanium, carbon fiber or  |                            |
| L5960      | Addition, endoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber  |                            |
| L5961      | Addition, endoskeletal system, polycentric hip joint, pneumatic or hydraulic control, rotation  |                            |
| L5964      | Addition, endoskeletal system, above knee, flexible protective outer surface covering system  |                            |
| L5966      | Addition, endoskeletal system, hip disarticulation, flexible protective outer surface covering  |                            |
| L5968      | Addition to lower limb prosthesis, multiaxial ankle with swing phase active dorsiflexion  |                            |
| L5973      | Endoskeletal ankle foot system, microprocessor controlled feature, dorsiflexion and/or  |                            |
| L5979      | All lower extremity prosthesis, multiaxial ankle, dynamic response foot, one piece system   |                            |
| L5980      | All lower extremity prostheses, flex foot system  |                            |
| L5981      | All lower extremity prostheses, flex-walk system or equal   |                            |
| L5987      | All lower extremity prosthesis, shank foot system with vertical loading pylon   |                            |
| L5988      | Addition to lower limb prosthesis, vertical shock reducing pylon feature  |                            |
| L5990      | Addition to lower extremity prosthesis, user adjustable heel height   |                            |
| L6026      | Transcarpal/metacarpal or partial hand disarticulation prosthesis, external power, self-  |                            |
| L6028      | Partial hand, finger, and thumb prosthesis without prosthetic digit(s)/thumb, amputation at metacarpal level, including flexible or non-flexible interface, molded to patient model, including palm, for use without external power and/or passive prosthetic digit/thumb, not including inserts described by I6692 | Effective 4/1/25           |
| L6034      | Partial hand, finger, and thumb prosthesis without prosthetic digit(s)/thumb, amputation at transmetacarpal level, including flexible or non-flexible interface, molded to patient model, for use without external power and/or passive prosthetic digit/thumb, not including inserts described by I6692            | Effective 1/1/26           |

| HCPCS Code | DME Description  | Comments/ Limitations |
|------------|--|-----------------------|
| L6035      | Single prosthetic digit, mechanical, can include metacarpophalangeal (mcp), proximal interphalangeal (pip), and/or distal interphalangeal (dip) joint(s), with or without locking mechanism, can include flexion or extension assist, any material, attachment, initial issue or replacement | Effective 1/1/26      |
| L6036      | Prosthetic thumb, mechanical, can include metacarpophalangeal (mcp), interphalangeal (ip) joint(s), with or without locking mechanism, can include flexion or extension assist, any material, attachment, initial issue or replacement   | Effective 1/1/26      |
| L6038      | Addition to single prosthetic digit or thumb, mechanical, attachment, multiaxial and/or internal/external rotation/abduction/adduction mechanism, with or without locking feature, any material  | Effective 1/1/26      |
| L6039      | Passive prosthetic digit or thumb prosthesis not including hand restoration partial hand, full or partial, custom made, any material, initial or replacement, per single passive prosthetic digit or thumb   | Effective 1/1/26      |
| L6050      | Wrist disarticulation, molded socket, flexible elbow hinges, triceps pad   |                       |
| L6055      | Wrist disarticulation, molded socket with expandable interface, flexible elbow hinges, triceps   |                       |
| L6100      | Below elbow, molded socket, flexible elbow hinge, triceps pad  |                       |
| L6110      | Below elbow, molded socket, (Muenster or Northwestern suspension types)  |                       |
| L6120      | Below elbow, molded double wall split socket, step-up hinges, half cuff  |                       |
| L6130      | Below elbow, molded double wall split socket, stump activated locking hinge, half cuff   |                       |
| L6200      | Elbow disarticulation, molded socket, outside locking hinge, forearm   |                       |
| L6205      | Elbow disarticulation, molded socket with expandable interface, outside locking hinges,  |                       |
| L6250      | Above elbow, molded double wall socket, internal locking elbow, forearm  |                       |
| L6300      | Shoulder disarticulation, molded socket, shoulder bulkhead, humeral section, internal locking  |                       |
| L6310      | Shoulder disarticulation, passive restoration (complete prosthesis)  |                       |
| L6320      | Shoulder disarticulation, passive restoration (shoulder cap only)  |                       |
| L6350      | Interscapular thoracic, molded socket, shoulder bulkhead, humeral section, internal locking  |                       |
| L6360      | Interscapular thoracic, passive restoration (complete prosthesis)  |                       |
| L6370      | Interscapular thoracic, passive restoration (shoulder cap only)  |                       |

| HCPCS Code | DME Description  | Comments/ Limitations |
|------------|--|-----------------------|
| L6380      | Immediate post surgical or early fitting, application of initial rigid dressing, including fitting |                       |
| L6382      | Immediate post surgical or early fitting, application of initial rigid dressing including fitting  |                       |
| L6384      | Immediate post surgical or early fitting, application of initial rigid dressing including fitting  |                       |
| L6400      | Below elbow, molded socket, endoskeletal system, including soft prosthetic tissue shaping          |                       |
| L6450      | Elbow disarticulation, molded socket, endoskeletal system, including soft prosthetic tissue        |                       |
| L6500      | Above elbow, molded socket, endoskeletal system, including soft prosthetic tissue shaping          |                       |
| L6550      | Shoulder disarticulation, molded socket, endoskeletal system, including soft prosthetic tissue     |                       |
| L6570      | Interscapular thoracic, molded socket, endoskeletal system, including soft prosthetic tissue       |                       |
| L6580      | Preparatory, wrist disarticulation or below elbow, single wall plastic socket, friction wrist,     |                       |
| L6582      | Preparatory, wrist disarticulation or below elbow, single wall socket, friction wrist, flexible    |                       |
| L6584      | Preparatory, elbow disarticulation or above elbow, single wall plastic socket, friction wrist,     |                       |
| L6586      | Preparatory, elbow disarticulation or above elbow, single wall socket, friction wrist, locking     |                       |
| L6588      | Preparatory, shoulder disarticulation or interscapular thoracic, single wall plastic socket,       |                       |
| L6590      | Preparatory, shoulder disarticulation or interscapular thoracic, single wall socket, shoulder      |                       |
| L6621      | Upper extremity prosthesis addition, flexion/extension wrist with or without friction, for use     |                       |
| L6624      | Upper extremity addition, flexion/extension and rotation wrist unit                                |                       |
| L6638      | Upper extremity addition to prosthesis, electric locking feature, only for use with manually       |                       |
| L6646      | Upper extremity addition, shoulder joint, multipositional locking, flexion, adjustable             |                       |
| L6648      | Upper extremity addition, shoulder lock mechanism, external powered actuator                       |                       |
| L6693      | Upper extremity addition, locking elbow, forearm counterbalance                                    |                       |
| L6696      | Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated socket          |                       |
| L6697      | Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated socket          |                       |
| L6700      | Upper extremity addition, external powered feature, myoelectronic control module,                  | Effective 4/1/25      |
| L6707      | Terminal device, hook, mechanical, voluntary closing, any material, any size, lined or unlined     |                       |
| L6708      | Terminal device, hand, mechanical, voluntary opening, any material, any size                       |                       |

| HCPCS Code | DME Description   | Comments/ Limitations |
|------------|---|-----------------------|
| L6709      | Terminal device, hand, mechanical, voluntary closing, any material, any size                    |                       |
| L6712      | Terminal device, hook, mechanical, voluntary closing, any material, any size, lined or unlined, |                       |
| L6713      | Terminal device, hand, mechanical, voluntary opening, any material, any size, pediatric         |                       |
| L6714      | Terminal device, hand, mechanical, voluntary closing, any material, any size, pediatric         |                       |
| L6715      | Terminal device, multiple articulating digit, includes motor(s), initial issue or replacement   |                       |
| L6721      | Terminal device, hook or hand, heavy duty, mechanical, voluntary opening, any material, any     |                       |
| L6722      | Terminal device, hook or hand, heavy duty, mechanical, voluntary closing, any material, any     |                       |
| L6880      | Electric hand, switch or myoelectric controlled, independently articulating digits, any grasp   |                       |
| L6881      | Automatic grasp feature, addition to upper limb electric prosthetic terminal device             |                       |
| L6882      | Microprocessor control feature, addition to upper limb prosthetic terminal device               |                       |
| L6883      | Replacement socket, below elbow/wrist disarticulation, molded to patient model, for use         |                       |
| L6884      | Replacement socket, above elbow/elbow disarticulation, molded to patient model, for use         |                       |
| L6885      | Replacement socket, shoulder disarticulation/interscapular thoracic, molded to patient          |                       |
| L6900      | Hand restoration (casts, shading and measurements included), partial hand, with glove,          |                       |
| L6905      | Hand restoration (casts, shading and measurements included), partial hand, with glove,          |                       |
| L6910      | Hand restoration (casts, shading and measurements included), partial hand, with glove, no       |                       |
| L6920      | Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell,    |                       |
| L6925      | Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell,    |                       |
| L6930      | Below elbow, external power, self-suspended inner socket, removable forearm shell, Otto         |                       |
| L6935      | Below elbow, external power, self-suspended inner socket, removable forearm shell, Otto         |                       |
| L6940      | Elbow disarticulation, external power, molded inner socket, removable humeral shell,            |                       |
| L6945      | Elbow disarticulation, external power, molded inner socket, removable humeral shell,            |                       |
| L6950      | above elbow, external power, molded inner socket, removable humeral shell, internal locking     |                       |
| L6955      | Above elbow, external power, molded inner socket, removable humeral shell, internal             |                       |
| L6960      | Shoulder disarticulation, external power, molded inner socket, removable shoulder shell,        |                       |

| HCPCS Code | DME Description   | Comments/ Limitations |
|------------|---|-----------------------|
| L6965      | Shoulder disarticulation, external power, molded inner socket, removable shoulder shell,  |                       |
| L6970      | interscapular-thoracic, external power, molded inner socket, removable shoulder shell,    |                       |
| L6975      | Interscapular-thoracic, external power, molded inner socket, removable shoulder shell,    |                       |
| L7007      | Electric hand, switch or myoelectric controlled, adult                                    |                       |
| L7008      | Electric hand, switch or myoelectric, controlled, pediatric                               |                       |
| L7009      | Electric hook, switch or myoelectric controlled, adult                                    |                       |
| L7040      | Prehensile actuator, switch controlled  |                       |
| L7045      | Electric hook, switch or myoelectric controlled, pediatric                                |                       |
| L7170      | Electronic elbow, Hosmer or equal, switch controlled                                      |                       |
| L7180      | Electronic elbow, microprocessor sequential control of elbow and terminal device          |                       |
| L7181      | Electronic elbow, microprocessor simultaneous control of elbow and terminal device        |                       |
| L7185      | Electronic elbow, adolescent, Variety Village or equal, switch controlled                 |                       |
| L7186      | Electronic elbow, child, Variety Village or equal, switch controlled                      |                       |
| L7190      | Electronic elbow, adolescent, Variety Village or equal, myoelectronically controlled      |                       |
| L7191      | Electronic elbow, child, Variety Village or equal, myoelectronically controlled           |                       |
| L7259      | Electronic wrist rotator, any type  |                       |
| L7406      | Addition to upper extremity prosthesis, user adjustable, mechanical, residual limb volume | Effective 4/1/25      |
| L8035      | Custom breast prosthesis, post mastectomy, molded to patient model                        |                       |
| L8040      | Nasal prosthesis, provided by a non-physician   |                       |
| L8041      | Midfacial prosthesis, provided by a non-physician   |                       |
| L8042      | Orbital prosthesis, provided by a non-physician   |                       |
| L8043      | Upper facial prosthesis, provided by a non-physician                                      |                       |
| L8044      | Hemi-facial prosthesis, provided by a non-physician                                       |                       |
| L8045      | Auricular prosthesis, provided by a non-physician   |                       |
| L8046      | Partial facial prosthesis, provided by a non-physician                                    |                       |

| HCPCS Code | DME Description  | Comments/ Limitations |
|------------|--|-----------------------|
| L8047      | Nasal septal prosthesis, provided by a non-physician   |                       |
| L8609      | Artificial cornea  |                       |
| L8614      | Cochlear device, includes all internal and external components                               |                       |
| L8615      | Headset/headpiece for use with cochlear implant device, replacement                          |                       |
| L8616      | Microphone for use with cochlear implant device, replacement                                 |                       |
| L8617      | Transmitting coil for use with cochlear implant device, replacement                          |                       |
| L8618      | Transmitter cable for use with cochlear implant device, replacement                          |                       |
| L8619      | Cochlear implant, external speech processor and controller, integrated system, replacement   |                       |
| L8627      | Cochlear implant, external speech processor, component, replacement                          |                       |
| L8628      | Cochlear implant, external controller component, replacement                                 |                       |
| L8629      | Transmitting coil and cable, integrated, for use with cochlear implant device, replacement   |                       |
| L8631      | Metacarpal phalangeal joint replacement, two or more pieces, metal (e.g., stainless steel or |                       |
| L8659      | Interphalangeal finger joint replacement, 2 or more pieces, metal (e.g., stainless steel or  |                       |
| L8679      | Implantable neurostimulator, pulse generator, any type                                       |                       |
| L8680      | Implantable neurostimulator electrode, each  | Effective 1/1/25      |
| L8682      | Implantable neurostimulator radio frequency receiver   |                       |
| L8683      | Radiofrequency transmitter (external) for use with implantable neurostimulator               |                       |
| L8685      | Implantable neurostimulator pulse generator, single array, rechargeable, includes extension  | Effective 1/1/25      |
| L8686      | Implantable neurostimulator pulse generator, single array, non-rechargeable, includes        | Effective 1/1/25      |
| L8687      | Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension    | Effective 1/1/25      |
| L8688      | Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes          | Effective 1/1/25      |
| L8690      | Auditory osseointegrated device, includes all internal and external components               |                       |
| L8691      | Auditory osseointegrated device, external sound processor, excludes transducer/actuator,     |                       |
| L8692      | Auditory osseointegrated device, external sound processor, used without osseointegration,    |                       |
| L8693      | Auditory osseointegrated device abutment, any length, replacement only                       |                       |

| HCPCS Code | DME Description   | Comments/ Limitations |
|------------|---|-----------------------|
| L8694      | Auditory osseointegrated device, transducer/actuator, replacement only, each                  |                       |
| L8720      | External lower extremity sensory prosthetic device, cutaneous stimulation of                  | Effective 10/1/24     |
| L8721      | Receptor sole for use with l8720, replacement, each   | Effective 10/1/24     |
| Q0479      | Power module for use with electric or electric/pneumatic ventricular assist device,           |                       |
| Q0480      | Driver for use with pneumatic ventricular assist device, replacement only                     |                       |
| Q0481      | Microprocessor control unit for use with electric ventricular assist device, replacement only |                       |
| Q0482      | Microprocessor control unit for use with electric/pneumatic combination ventricular assist    |                       |
| Q0483      | Monitor/display module for use with electric ventricular assist device, replacement only      |                       |
| Q0484      | Monitor/display module for use with electric or electric/pneumatic ventricular assist device, |                       |
| Q0489      | Power pack base for use with electric/pneumatic ventricular assist device, replacement only   |                       |
| Q0491      | Emergency power source for use with electric/pneumatic ventricular assist device,             |                       |
| V2623      | Prosthetic eye, plastic, custom   |                       |
| V2627      | Scleral cover shell   |                       |