



# BlueCross BlueShield of Illinois

## Illinois Medicaid Prior Authorization Code List, Effective 11/1/2025

This list includes Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System codes related to services and categories for which prior authorization may be required.

This list is not exhaustive. The presence of codes on this list does not necessarily indicate coverage under the member benefits contract. Always check eligibility and benefits first, prior to rendering services.

Member contracts differ in their benefits. Consult the member benefit booklet or a customer service representative to determine coverage for a specific medical service or supply.

**Green highlighted codes are managed by Carelon Medical Benefits Management for Medicaid members with Blue Cross Community Health Plans™.**

*This file is a searchable PDF.  
Use <CTRL F> to find your selected criteria.*

### IMPORTANT LINKS:

[Medical Policies for Blue Cross and Blue Shield of Illinois](#)

[Carelon Medical Policies](#)

[Prescription Drug Benefits](#)

For American Society of Addiction Medicine Criteria and MCG Care Guidelines, visit: [Availity® Essentials](#)

**OUT-OF-NETWORK REMINDER: Prior authorization is required for any services provided by out-of-network providers.**

| CPT and HCPCS Codes | Description of Procedure Code      | Medical Records Request Information Required                                                          | Clinical Criteria Category               | Clinical Criteria Hierarchy                            | Medical Policy Number                  | Medical Policy Name                                                                                                                                                                 | Effective and Change Date | Date Posted to Website* |
|---------------------|------------------------------------|-------------------------------------------------------------------------------------------------------|------------------------------------------|--------------------------------------------------------|----------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------|
| 11950               | TX CONTOUR DEFECTS 1 CC/<          | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual Medical Policy, MCG  | SUR716.001<br>SUR717.001<br>SUR706.009 | Cosmetic and Reconstructive Procedures<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Sleep Related Breathing Disorders: Surgical Management | Added prior to 9/1/2019   |                         |
| 11951               | TX CONTOUR DEFECTS 1.1-5.0CC       | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual Medical Policy, MCG  | SUR716.001<br>SUR717.001<br>SUR706.009 | Cosmetic and Reconstructive Procedures<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Sleep Related Breathing Disorders: Surgical Management | Added prior to 9/1/2019   |                         |
| 11952               | TX CONTOUR DEFECTS 5.1-10CC        | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual Medical Policy, MCG  | SUR716.001<br>SUR717.001<br>SUR706.009 | Cosmetic and Reconstructive Procedures<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Sleep Related Breathing Disorders: Surgical Management | Added prior to 9/1/2019   |                         |
| 11954               | TX CONTOUR DEFECTS >10.0 CC        | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR716.001<br>SUR717.001<br>SUR706.009 | Cosmetic and Reconstructive Procedures<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Sleep Related Breathing Disorders: Surgical Management | Added prior to 9/1/2019   |                         |
| 11960               | INSERT TISSUE EXPANDER(S)          | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR716.001                             | Cosmetic and Reconstructive Procedures                                                                                                                                              | Added prior to 9/1/2019   |                         |
| 14021               | SCALP ADVANCEMENT OR REDUCTION     | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR717.001                             | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                                                                     | Added 1/1/23              |                         |
| 15756               | Implants (gluteal, calf, pectoral) | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR717.001                             | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                                                                     | Added 1/1/23              |                         |
| 15777               | Implants (gluteal, calf, pectoral) | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR717.001                             | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                                                                     | Added 1/1/23              |                         |

| CPT and HCPCS Codes | Description of Procedure Code | Medical Records Request Information Required                                                                                           | Clinical Criteria Category               | Clinical Criteria Hierarchy                            | Medical Policy Number                                | Medical Policy Name                                                                                                                                                                   | Effective and Change Date | Date Posted to Website* |
|---------------------|-------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|--------------------------------------------------------|------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------|
| 15780               | DERMABRASION TOTAL FACE       | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                  | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | THE801.028<br>SUR716.001<br>SUR717.001<br>THE801.030 | Acne Management<br>Cosmetic and Reconstructive Procedures<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Nonpharmacologic Treatment of Rosacea | Added prior to 9/1/2019   |                         |
| 15781               | DERMABRASION SEGMENTAL FACE   | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                  | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | THE801.028<br>SUR716.001<br>SUR717.001<br>THE801.030 | Acne Management<br>Cosmetic and Reconstructive Procedures<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Nonpharmacologic Treatment of Rosacea | Added prior to 9/1/2019   |                         |
| 15782               | DERMABRASION OTHER THAN FACE  | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                  | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | THE801.028<br>SUR716.001<br>SUR717.001<br>THE801.030 | Acne Management<br>Cosmetic and Reconstructive Procedures<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Nonpharmacologic Treatment of Rosacea | Added prior to 9/1/2019   |                         |
| 15783               | DERMABRASION SUPRFL ANY SITE  | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                  | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | THE801.028<br>SUR716.001<br>SUR717.001<br>THE801.030 | Acne Management<br>Cosmetic and Reconstructive Procedures<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Nonpharmacologic Treatment of Rosacea | Added prior to 9/1/2019   |                         |
| 15788               | CHEMICAL PEEL FACE EPIDERM    | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                  | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | THE801.028<br>SUR716.018<br>SUR717.001<br>THE801.030 | Acne Management<br>Chemical Peels<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Nonpharmacologic Treatment of Rosacea                         | Added prior to 9/1/2019   |                         |
| 15789               | CHEMICAL PEEL FACE DERMAL     | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                  | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | THE801.028<br>SUR716.018<br>SUR717.001<br>THE801.030 | Acne Management<br>Chemical Peels<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Nonpharmacologic Treatment of Rosacea                         | Added prior to 9/1/2019   |                         |
| 15792               | CHEMICAL PEEL NONFACIAL       | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                  | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | THE801.028<br>SUR716.018<br>SUR717.001<br>THE801.030 | Acne Management<br>Chemical Peels<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Nonpharmacologic Treatment of Rosacea                         | Added prior to 9/1/2019   |                         |
| 15793               | CHEMICAL PEEL NONFACIAL       | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                  | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | THE801.028<br>SUR716.018<br>SUR717.001<br>THE801.030 | Acne Management<br>Chemical Peels<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Nonpharmacologic Treatment of Rosacea                         | Added prior to 9/1/2019   |                         |
| 15819               | PLASTIC SURGERY NECK          | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                  | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR716.001                                           | Cosmetic and Reconstructive Procedures                                                                                                                                                | Added prior to 9/1/2019   |                         |
| 15820               | REVISION OF LOWER EYELID      | Pre-operative Evaluation, history and physical including functional impairment, operative report and photographs of the affected eyes. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR716.004<br>SUR717.001                             | Blepharoplasty, Blepharoptosis and Brow Repair<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                     | Added prior to 9/1/2019   |                         |
| 15821               | REVISION OF LOWER EYELID      | Pre-operative Evaluation, history and physical including functional impairment, operative report and photographs of the affected eyes. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR716.004<br>SUR717.001                             | Blepharoplasty, Blepharoptosis and Brow Repair<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                     | Added prior to 9/1/2019   |                         |
| 15822               | REVISION OF UPPER EYELID      | Pre-operative Evaluation, history and physical including functional impairment, operative report and photographs of the affected eyes. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR716.004<br>SUR717.001                             | Blepharoplasty, Blepharoptosis and Brow Repair<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                     | Added prior to 9/1/2019   |                         |
| 15823               | REVISION OF UPPER EYELID      | Pre-operative Evaluation, history and physical including functional impairment, operative report and photographs of the affected eyes. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR716.004<br>SUR717.001                             | Blepharoplasty, Blepharoptosis and Brow Repair<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                     | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code | Medical Records Request Information Required                                                          | Clinical Criteria Category               | Clinical Criteria Hierarchy                            | Medical Policy Number                  | Medical Policy Name                                                                                                                                                          | Effective and Change Date | Date Posted to Website* |
|---------------------|-------------------------------|-------------------------------------------------------------------------------------------------------|------------------------------------------|--------------------------------------------------------|----------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------|
| 15824               | REMOVAL OF FOREHEAD WRINKLES  | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR716.001<br>SUR717.001<br>SUR712.031 | Cosmetic and Reconstructive Procedures<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Surgical Deactivation of Headache Trigger Sites | Added prior to 9/1/2019   |                         |
| 15825               | REMOVAL OF NECK WRINKLES      | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR716.001<br>SUR717.001               | Cosmetic and Reconstructive Procedures<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                    | Added prior to 9/1/2019   |                         |
| 15826               | REMOVAL OF BROW WRINKLES      | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR716.001<br>SUR717.001<br>SUR712.031 | Cosmetic and Reconstructive Procedures<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Surgical Deactivation of Headache Trigger Sites | Added prior to 9/1/2019   |                         |
| 15828               | REMOVAL OF FACE WRINKLES      | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR716.001<br>SUR717.001               | Cosmetic and Reconstructive Procedures<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                    | Added prior to 9/1/2019   |                         |
| 15829               | REMOVAL OF SKIN WRINKLES      | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR716.001                             | Cosmetic and Reconstructive Procedures                                                                                                                                       | Added prior to 9/1/2019   |                         |
| 15830               | EXC SKIN ABD                  | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR716.001<br>SUR717.001<br>SUR701.024 | Cosmetic and Reconstructive Procedures<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Surgery for Lipedema and Lymphedema             | Added prior to 9/1/2019   |                         |
| 15831               | EXC SKIN ABD                  | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR717.001                             | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                                                              | Added 1/1/23              |                         |
| 15832               | EXCISE EXCESSIVE SKIN THIGH   | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR716.001<br>SUR717.001<br>SUR701.024 | Cosmetic and Reconstructive Procedures<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Surgery for Lipedema and Lymphedema             | Added prior to 9/1/2019   |                         |
| 15833               | EXCISE EXCESSIVE SKIN LEG     | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR716.001<br>SUR717.001<br>SUR701.024 | Cosmetic and Reconstructive Procedures<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Surgery for Lipedema and Lymphedema             | Added prior to 9/1/2019   |                         |
| 15834               | EXCISE EXCESSIVE SKIN HIP     | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR716.001<br>SUR717.001<br>SUR701.024 | Cosmetic and Reconstructive Procedures<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Surgery for Lipedema and Lymphedema             | Added prior to 9/1/2019   |                         |
| 15835               | EXCISE EXCESSIVE SKIN BUTTCK  | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR716.001<br>SUR717.001<br>SUR701.024 | Cosmetic and Reconstructive Procedures<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Surgery for Lipedema and Lymphedema             | Added prior to 9/1/2019   |                         |
| 15836               | EXCISE EXCESSIVE SKIN ARM     | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR716.001<br>SUR717.001<br>SUR701.024 | Cosmetic and Reconstructive Procedures<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Surgery for Lipedema and Lymphedema             | Added prior to 9/1/2019   |                         |
| 15837               | EXCISE EXCESS SKIN ARM/HAND   | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR716.001<br>SUR717.001<br>SUR701.024 | Cosmetic and Reconstructive Procedures<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Surgery for Lipedema and Lymphedema             | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code | Medical Records Request Information Required                                                          | Clinical Criteria Category               | Clinical Criteria Hierarchy                            | Medical Policy Number                                | Medical Policy Name                                                                                                                                                                                    | Effective and Change Date | Date Posted to Website* |
|---------------------|-------------------------------|-------------------------------------------------------------------------------------------------------|------------------------------------------|--------------------------------------------------------|------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------|
| 15838               | EXCISE EXCESS SKIN FAT PAD    | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR716.001<br>SUR717.001<br>SUR701.024               | Cosmetic and Reconstructive Procedures<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Surgery for Lipedema and Lymphedema                                       | Added prior to 9/1/2019   |                         |
| 15839               | EXCISE EXCESS SKIN & TISSUE   | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR716.001<br>SUR717.001<br>SUR701.024<br>SUR716.017 | Cosmetic and Reconstructive Procedures<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Surgery for Lipedema and Lymphedema<br>Surgical Treatment of Gynecomastia | Added prior to 9/1/2019   |                         |
| 15847               | EXC SKIN ABD ADD-ON           | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR716.001<br>SUR701.024                             | Cosmetic and Reconstructive Procedures<br>Surgery for Lipedema and Lymphedema                                                                                                                          | Added prior to 9/1/2019   |                         |
| 15876               | SUCTION LIPECTOMY HEAD&NECK   | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR716.001<br>SUR717.001<br>SUR701.024               | Cosmetic and Reconstructive Procedures<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Surgery for Lipedema and Lymphedema                                       | Added prior to 9/1/2019   |                         |
| 15877               | SUCTION LIPECTOMY TRUNK       | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR716.001<br>SUR717.001<br>SUR701.024               | Cosmetic and Reconstructive Procedures<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Surgery for Lipedema and Lymphedema                                       | Added prior to 9/1/2019   |                         |
| 15878               | SUCTION LIPECTOMY UPR EXTREM  | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR716.001<br>SUR717.001<br>SUR701.024               | Cosmetic and Reconstructive Procedures<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Surgery for Lipedema and Lymphedema                                       | Added prior to 9/1/2019   |                         |
| 15879               | SUCTION LIPECTOMY LWR EXTREM  | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR716.001<br>SUR717.001<br>SUR701.024               | Cosmetic and Reconstructive Procedures<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Surgery for Lipedema and Lymphedema                                       | Added prior to 9/1/2019   |                         |
| 17106               | DESTRUCTION OF SKIN LESIONS   | Letter of medical necessity, including condition being treated.                                       | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | THE801.028<br>SUR704.008<br>THE801.030               | Acne Management<br>Laser Treatment of Congenital Port Wine Stain (PWS), Hemangiomas, and Other External Vascular Malformations<br>Nonpharmacologic Treatment of Rosacea                                | Added 1/1/23              |                         |
| 17107               | DESTRUCTION OF SKIN LESIONS   | Letter of medical necessity, including condition being treated.                                       | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | THE801.028<br>SUR704.008<br>THE801.030               | Acne Management<br>Laser Treatment of Congenital Port Wine Stain (PWS), Hemangiomas, and Other External Vascular Malformations<br>Nonpharmacologic Treatment of Rosacea                                | Added prior to 9/1/2019   |                         |
| 17108               | DESTRUCTION OF SKIN LESIONS   | Letter of medical necessity, including condition being treated.                                       | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | THE801.028<br>SUR704.008<br>THE801.031               | Acne Management<br>Laser Treatment of Congenital Port Wine Stain (PWS), Hemangiomas, and Other External Vascular Malformations<br>Nonpharmacologic Treatment of Rosacea                                | Added 1/1/23              |                         |
| 17340               | CRYOTHERAPY OF SKIN           | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | THE801.028                                           | Acne Management                                                                                                                                                                                        | Added prior to 9/1/2019   |                         |
| 17360               | SKIN PEEL THERAPY             | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | THE801.028                                           | Acne Management                                                                                                                                                                                        | Added prior to 9/1/2019   |                         |
| 17380               | HAIR REMOVAL BY ELECTROLYSIS  | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR716.001<br>SUR717.001                             | Cosmetic and Reconstructive Procedures<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                                              | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code | Medical Records Request Information Required                                                                                                            | Clinical Criteria Category               | Clinical Criteria Hierarchy                              | Medical Policy Number                                | Medical Policy Name                                                                                                                                                                 | Effective and Change Date | Date Posted to Website* |
|---------------------|-------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|----------------------------------------------------------|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------|
| 19294               | IORT BREAST                   | Carelon-https://providerportal.com/ or 866-455-8415                                                                                                     | Radiation Therapy                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                                              | Carelon                                                                                                                                                                             | Change 8/1/2025           |                         |
| 19296               | Place po breast cath for rad  | Carelon-https://providerportal.com/ or 866-455-8415                                                                                                     | Radiation Therapy                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                                              | Carelon                                                                                                                                                                             | Change 8/1/2025           |                         |
| 19297               | Place breast cath for rad     | Carelon-https://providerportal.com/ or 866-455-8415                                                                                                     | Radiation Therapy                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                                              | Carelon                                                                                                                                                                             | Change 8/1/2025           |                         |
| 19298               | Place breast rad tube/caths   | Carelon-https://providerportal.com/ or 866-455-8415                                                                                                     | Radiation Therapy                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                                              | Carelon                                                                                                                                                                             | Change 8/1/2025           |                         |
| 19303               | MASTECTOMY                    | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                                   | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG   | SURG717.001<br>SURG716.015                           | Cosmetic and Reconstructive Procedures<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Risk reducing (Prophylactic) Mastectomy                   | Added 1/1/23              |                         |
| 19316               | SUSPENSION OF BREAST          | Pre-operative evaluation, history and physical including functional impairment and operative report.                                                    | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG   | SUR717.001<br>SUR716.010<br>SUR716.011               | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Mastopexy<br>Reconstructive Breast Surgery                                                       | Added prior to 9/1/2019   |                         |
| 19318               | REDUCTION OF LARGE BREAST     | Pre-operative evaluation, height/ weight, previous conservative treatment tried, pathology report, operative report, number of grams of tissue removed. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG   | SUR716.001<br>SUR717.001<br>SUR716.011<br>SUR716.012 | Cosmetic and Reconstructive Procedures<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Reconstructive Breast Surgery<br>Reduction Mammoplasty | Added prior to 9/1/2019   |                         |
| 19324               | ENLARGE BREAST                | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                                   | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG   | SUR717.001<br>SUR716.011                             | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Reconstructive Breast Surgery                                                                    | Added prior to 9/1/2019   |                         |
| 19325               | ENLARGE BREAST WITH IMPLANT   | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                                   | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG   | SUR717.001<br>SUR716.011                             | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Reconstructive Breast Surgery                                                                    | Added prior to 9/1/2019   |                         |
| 19328               | REMOVAL OF BREAST IMPLANT     | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                                   | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG   | SUR716.009<br>SUR716.011                             | Breast Implant, Removal and/or Insertion<br>Reconstructive Breast Surgery                                                                                                           | Added prior to 9/1/2019   |                         |
| 19330               | REMOVAL OF IMPLANT MATERIAL   | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                                   | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG   | SUR716.009<br>SUR716.011                             | Breast Implant, Removal and/or Insertion<br>Reconstructive Breast Surgery                                                                                                           | Added prior to 9/1/2019   |                         |
| 19350               | nipple graft                  | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                                   | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG   | SUR717.001,<br>SUR716.011                            | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Reconstructive Breast Surgery                                                                    | Added 1/1/23              |                         |
| 19357               | BREAST AUGMENTATION           | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                                   | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG   | SUR716.011                                           | Reconstructive Breast Surgery                                                                                                                                                       | Added 1/1/23              |                         |
| 19361               | BREAST AUGMENTATION           | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                                   | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG   | SUR716.011                                           | Reconstructive Breast Surgery                                                                                                                                                       | Added 1/1/23              |                         |
| 19364               | BREAST AUGMENTATION           | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                                   | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG   | SUR716.011                                           | Reconstructive Breast Surgery                                                                                                                                                       | Added 1/1/23              |                         |
| 19367               | BREAST AUGMENTATION           | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                                   | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG   | SUR716.011                                           | Reconstructive Breast Surgery                                                                                                                                                       | Added 1/1/23              |                         |
| 19368               | BREAST AUGMENTATION           | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                                   | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG   | SUR716.011                                           | Reconstructive Breast Surgery                                                                                                                                                       | Added 1/1/23              |                         |
| 19369               | BREAST AUGMENTATION           | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                                   | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG   | SUR716.011                                           | Reconstructive Breast Surgery                                                                                                                                                       | Added 1/1/23              |                         |
| 19370               | BREAST AUGMENTATION           | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                                   | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG   | SUR716.011                                           | Reconstructive Breast Surgery                                                                                                                                                       | Added 1/1/23              |                         |
| 19371               | BREAST AUGMENTATION           | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                                   | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG   | SUR716.011<br>SUR716.009                             | Reconstructive Breast Surgery<br>Breast Implant, Removal and/or Insertion                                                                                                           | Added 1/1/23              |                         |
| 19373               | BREAST AUGMENTATION           | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                                   | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG   | SUR717.001                                           | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                                                                     | Added 1/1/23              |                         |
| 19380               | BREAST AUGMENTATION           | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                                   | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG   | SUR716.021,<br>SUR716.011,<br>SUR716.009             | Adipose-Derived Stem Cells in Autologous Fat Grafting to the Breast<br>Reconstructive Breast Surgery<br>Breast Implant, Removal and/or Insertion                                    | Added 1/1/23              |                         |
| 20555               | PLACE NDL MUSC/TIS FOR RT     | Carelon-https://providerportal.com/ or 866-455-8415                                                                                                     | Radiation Therapy                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                                              | Carelon                                                                                                                                                                             | Change 8/1/2025           |                         |
| 20930               | SP BONE ALGRFT MORSEL ADD-ON  | Carelon-https://providerportal.com/ or 866-455-8415                                                                                                     | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                                              | Carelon                                                                                                                                                                             | Change 8/1/2025           |                         |
| 20931               | SP BONE ALGRFT STRUCT ADD-ON  | Carelon-https://providerportal.com/ or 866-455-8415                                                                                                     | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                                              | Carelon                                                                                                                                                                             | Change 8/1/2025           |                         |

| CPT and HCPCS Codes | Description of Procedure Code | Medical Records Request Information Required                                                                                                 | Clinical Criteria Category               | Clinical Criteria Hierarchy                                                                                                     | Medical Policy Number                                              | Medical Policy Name                                                                                                                                                                                                                                           | Effective and Change Date | Date Posted to Website* |
|---------------------|-------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------|
| 20936               | SP BONE AGRFT LOCAL ADD-ON    | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                               | Musculoskeletal                          | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                                                            | Carelon                                                                                                                                                                                                                                                       | Change 8/1/2025           |                         |
| 20937               | SP BONE AGRFT MORSEL ADD-ON   | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                               | Musculoskeletal                          | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                                                            | Carelon                                                                                                                                                                                                                                                       | Change 8/1/2025           |                         |
| 20938               | SP BONE AGRFT STRUCT ADD-ON   | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                               | Musculoskeletal                          | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                                                            | Carelon                                                                                                                                                                                                                                                       | Change 8/1/2025           |                         |
| 20974               | ELECTRICAL BONE STIMULATION   | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                        | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SURG703.027<br>SURG705.013<br>SURG705.044                          | Progenitor Cell Therapy for the Treatment of Damaged Myocardium Due to Ischemia Electrical Stimulation of the Spine as an Adjunct to Spinal Fusion Procedures Electrical Bone Growth Stimulation of the Appendicular Skeleton                                 | Added prior to 9/1/2019   |                         |
| 20975               | ELECTRICAL BONE STIMULATION   | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                        | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SURG703.027<br>SURG705.013<br>SURG705.044                          | Progenitor Cell Therapy for the Treatment of Damaged Myocardium Due to Ischemia Electrical Stimulation of the Spine as an Adjunct to Spinal Fusion Procedures Electrical Bone Growth Stimulation of the Appendicular Skeleton                                 | Added prior to 9/1/2019   |                         |
| 21087               | CHIN/NOSE IMPLANT             | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                        | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SUR717.001                                                         | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                                                                                                                                               | Added 1/1/23              |                         |
| 21120               | RECONSTRUCTION OF CHIN        | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SUR716.001<br>SUR717.001<br>SUR705.030<br>SUR706.009<br>SUR705.010 | Cosmetic and Reconstructive Procedures<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Orthognathic Surgery<br>Sleep Related Breathing Disorders: Surgical Management<br>Temporomandibular Joint (TMJ) Disorders (TMJD) | Added prior to 9/1/2019   |                         |
| 21121               | RECONSTRUCTION OF CHIN        | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SUR716.001<br>SUR717.001<br>SUR705.030<br>SUR706.009<br>SUR705.010 | Cosmetic and Reconstructive Procedures<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Orthognathic Surgery<br>Sleep Related Breathing Disorders: Surgical Management<br>Temporomandibular Joint (TMJ) Disorders (TMJD) | Added prior to 9/1/2019   |                         |
| 21122               | RECONSTRUCTION OF CHIN        | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SUR716.001<br>SUR717.001<br>SUR705.030<br>SUR706.009<br>SUR705.010 | Cosmetic and Reconstructive Procedures<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Orthognathic Surgery<br>Sleep Related Breathing Disorders: Surgical Management<br>Temporomandibular Joint (TMJ) Disorders (TMJD) | Added prior to 9/1/2019   |                         |
| 21123               | RECONSTRUCTION OF CHIN        | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SUR716.001<br>SUR717.001<br>SUR705.030<br>SUR706.009<br>SUR705.010 | Cosmetic and Reconstructive Procedures<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Orthognathic Surgery<br>Sleep Related Breathing Disorders: Surgical Management<br>Temporomandibular Joint (TMJ) Disorders (TMJD) | Added prior to 9/1/2019   |                         |
| 21125               | AUGMENTATION LOWER JAW BONE   | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SUR717.001<br>SUR705.030                                           | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Orthognathic Surgery                                                                                                                                                       | Added prior to 9/1/2019   |                         |
| 21127               | AUGMENTATION LOWER JAW BONE   | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SUR717.001<br>SUR705.030<br>SUR706.009                             | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Orthognathic Surgery<br>Sleep Related Breathing Disorders: Surgical Management                                                                                             | Added prior to 9/1/2019   |                         |
| 21137               | FOREHEAD RECONSTRUCTION       | History and physical, documentation of medical necessity and previous stages of reconstruction if done.                                      | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SUR717.001                                                         | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                                                                                                                                               | Added 1/1/23              |                         |

| CPT and HCPCS Codes | Description of Procedure Code | Medical Records Request Information Required                                                                                                 | Clinical Criteria Category               | Clinical Criteria Hierarchy                            | Medical Policy Number                  | Medical Policy Name                                                                                                              | Effective and Change Date | Date Posted to Website* |
|---------------------|-------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|--------------------------------------------------------|----------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------|
| 21138               | REDUCTION OF FOREHEAD         | History and physical, documentation of medical necessity and previous stages of reconstruction if done.                                      | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR716.001                             | Cosmetic and Reconstructive Procedures                                                                                           | Added prior to 9/1/2019   |                         |
| 21139               | FOREHEAD RECONSTRUCTION       | History and physical, documentation of medical necessity and previous stages of reconstruction if done.                                      | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR717.001                             | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                  | Added 1/1/23              |                         |
| 21141               | LEFORT I-1 PIECE W/O GRAFT    | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR705.030<br>SUR706.009<br>SUR705.010 | Orthognathic Surgery<br>Sleep Related Breathing Disorders: Surgical Management<br>Temporomandibular Joint (TMJ) Disorders (TMJD) | Added prior to 9/1/2019   |                         |
| 21142               | LEFORT I-2 PIECE W/O GRAFT    | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR705.030<br>SUR706.009<br>SUR705.010 | Orthognathic Surgery<br>Sleep Related Breathing Disorders: Surgical Management<br>Temporomandibular Joint (TMJ) Disorders (TMJD) | Added prior to 9/1/2019   |                         |
| 21143               | LEFORT I-3/> PIECE W/O GRAFT  | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR705.030<br>SUR706.009<br>SUR705.010 | Orthognathic Surgery<br>Sleep Related Breathing Disorders: Surgical Management<br>Temporomandibular Joint (TMJ) Disorders (TMJD) | Added prior to 9/1/2019   |                         |
| 21145               | LEFORT I-1 PIECE W/ GRAFT     | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR705.030<br>SUR705.010               | Orthognathic Surgery<br>Temporomandibular Joint (TMJ) Disorders (TMJD)                                                           | Added prior to 9/1/2019   |                         |
| 21146               | LEFORT I-2 PIECE W/ GRAFT     | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR705.030<br>SUR705.010               | Orthognathic Surgery<br>Temporomandibular Joint (TMJ) Disorders (TMJD)                                                           | Added prior to 9/1/2019   |                         |
| 21147               | LEFORT I-3/> PIECE W/ GRAFT   | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR705.030<br>SUR705.010               | Orthognathic Surgery<br>Temporomandibular Joint (TMJ) Disorders (TMJD)                                                           | Added prior to 9/1/2019   |                         |
| 21150               | LEFORT II ANTERIOR INTRUSION  | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR705.030                             | Orthognathic Surgery                                                                                                             | Added prior to 9/1/2019   |                         |
| 21151               | LEFORT II W/BONE GRAFTS       | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR705.030                             | Orthognathic Surgery                                                                                                             | Added prior to 9/1/2019   |                         |
| 21154               | LEFORT III W/O LEFORT I       | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR705.030                             | Orthognathic Surgery                                                                                                             | Added prior to 9/1/2019   |                         |
| 21155               | LEFORT III W/ LEFORT I        | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR705.030                             | Orthognathic Surgery                                                                                                             | Added prior to 9/1/2019   |                         |
| 21159               | LEFORT III W/FHDW/O LEFORT I  | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR705.030                             | Orthognathic Surgery                                                                                                             | Added prior to 9/1/2019   |                         |
| 21160               | LEFORT III W/FHD W/ LEFORT I  | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR705.030                             | Orthognathic Surgery                                                                                                             | Added prior to 9/1/2019   |                         |
| 21188               | RECONSTRUCTION OF MIDFACE     | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                        | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR705.030                             | Orthognathic Surgery                                                                                                             | Added prior to 9/1/2019   |                         |
| 21193               | RECONST LWR JAW W/O GRAFT     | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR705.030<br>SUR706.009<br>SUR705.010 | Orthognathic Surgery<br>Sleep Related Breathing Disorders: Surgical Management<br>Temporomandibular Joint (TMJ) Disorders (TMJD) | Added prior to 9/1/2019   |                         |
| 21194               | RECONST LWR JAW W/GRAFT       | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR705.030<br>SUR706.009<br>SUR705.010 | Orthognathic Surgery<br>Sleep Related Breathing Disorders: Surgical Management<br>Temporomandibular Joint (TMJ) Disorders (TMJD) | Added prior to 9/1/2019   |                         |
| 21195               | RECONST LWR JAW W/O FIXATION  | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR705.030<br>SUR706.009<br>SUR705.010 | Orthognathic Surgery<br>Sleep Related Breathing Disorders: Surgical Management<br>Temporomandibular Joint (TMJ) Disorders (TMJD) | Added prior to 9/1/2019   |                         |
| 21196               | RECONST LWR JAW W/FIXATION    | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR705.030<br>SUR706.009<br>SUR705.010 | Orthognathic Surgery<br>Sleep Related Breathing Disorders: Surgical Management<br>Temporomandibular Joint (TMJ) Disorders (TMJD) | Added prior to 9/1/2019   |                         |
| 21198               | RECONST LWR JAW SEGMENT       | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR705.030<br>SUR706.009<br>SUR705.010 | Orthognathic Surgery<br>Sleep Related Breathing Disorders: Surgical Management<br>Temporomandibular Joint (TMJ) Disorders (TMJD) | Added prior to 9/1/2019   |                         |
| 21199               | RECONSTR LWR JAW W/ADVANCE    | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR705.030<br>SUR706.009<br>SUR705.010 | Orthognathic Surgery<br>Sleep Related Breathing Disorders: Surgical Management<br>Temporomandibular Joint (TMJ) Disorders (TMJD) | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code | Medical Records Request Information Required                                                                                                 | Clinical Criteria Category               | Clinical Criteria Hierarchy                                                                                                     | Medical Policy Number                  | Medical Policy Name                                                                                                                    | Effective and Change Date | Date Posted to Website* |
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| 21206               | RECONSTRUCT UPPER JAW BONE    | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SUR705.030                             | Orthognathic Surgery                                                                                                                   | Added prior to 9/1/2019   |                         |
| 21208               | AUGMENTATION OF FACIAL BONES  | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SUR705.030                             | Orthognathic Surgery                                                                                                                   | Added prior to 9/1/2019   |                         |
| 21209               | REDUCTION OF FACIAL BONES     | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SUR705.030                             | Orthognathic Surgery                                                                                                                   | Added prior to 9/1/2019   |                         |
| 21210               | FACE BONE GRAFT               | Submit history and physical, documentation of medical necessity including operative report.                                                  | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SUR705.028<br>SUR705.030<br>SUR706.009 | Neuralgia Inducing Cavitational Osteonecrosis (NICO)<br>Orthognathic Surgery<br>Sleep Related Breathing Disorders: Surgical Management | Added prior to 9/1/2019   |                         |
| 21215               | LOWER JAW BONE GRAFT          | Submit history and physical, documentation of medical necessity including operative report.                                                  | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SUR705.028<br>SUR705.030<br>SUR706.009 | Neuralgia Inducing Cavitational Osteonecrosis (NICO)<br>Orthognathic Surgery<br>Sleep Related Breathing Disorders: Surgical Management | Added prior to 9/1/2019   |                         |
| 21230               | RIB CARTILAGE GRAFT           | Submit history and physical, documentation of medical necessity including operative report.                                                  | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SUR705.030                             | Orthognathic Surgery                                                                                                                   | Added prior to 9/1/2019   |                         |
| 21244               | RECONSTRUCTION OF LOWER JAW   | Submit history and physical, documentation of medical necessity including operative report.                                                  | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SUR706.009                             | Sleep Related Breathing Disorders: Surgical Management                                                                                 | Added prior to 9/1/2019   |                         |
| 21245               | RECONSTRUCTION OF JAW         | Submit history and physical, documentation of medical necessity including operative report.                                                  | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SUR706.009                             | Sleep Related Breathing Disorders: Surgical Management                                                                                 | Added prior to 9/1/2019   |                         |
| 21246               | RECONSTRUCTION OF JAW         | Submit history and physical, documentation of medical necessity including operative report.                                                  | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SUR706.009                             | Sleep Related Breathing Disorders: Surgical Management                                                                                 | Added prior to 9/1/2019   |                         |
| 21270               | AUGMENTATION CHEEK BONE       | Submit history and physical, documentation of medical necessity including operative report.                                                  | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SUR716.001                             | Cosmetic and Reconstructive Procedures                                                                                                 | Added prior to 9/1/2019   |                         |
| 21685               | HYOID MYOTOMY & SUSPENSION    | Submit history and physical, documentation of medical necessity including operative report.                                                  | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SUR706.009                             | Sleep Related Breathing Disorders: Surgical Management                                                                                 | Added prior to 9/1/2019   |                         |
| 21740               | RECONSTRUCTION OF STERNUM     | Submit history and physical, documentation of medical necessity including operative report.                                                  | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SUR716.001                             | Cosmetic and Reconstructive Procedures                                                                                                 | Added prior to 9/1/2019   |                         |
| 22505               | MANIPULATION OF SPINE         | Submit history and physical, documentation of medical necessity including operative report.                                                  | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | THE803.016                             | Manipulation Under Anesthesia                                                                                                          | Added prior to 9/1/2019   |                         |
| 22510               | PERQ CERVICOTHORACIC INJECT   | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                               | Musculoskeletal                          | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                                | Carelon                                                                                                                                | Change 8/1/2025           |                         |
| 22511               | PERQ LUMBOSACRAL INJECTION    | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                               | Musculoskeletal                          | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                                | Carelon                                                                                                                                | Change 8/1/2025           |                         |
| 22512               | VERTEBROPLASTY ADDL INJECT    | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                               | Musculoskeletal                          | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                                | Carelon                                                                                                                                | Change 8/1/2025           |                         |
| 22513               | PERQ VERTEBRAL AUGMENTATION   | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                               | Musculoskeletal                          | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                                | Carelon                                                                                                                                | Change 8/1/2025           |                         |
| 22514               | PERQ VERTEBRAL AUGMENTATION   | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                               | Musculoskeletal                          | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                                | Carelon                                                                                                                                | Change 8/1/2025           |                         |
| 22515               | PERQ VERTEBRAL AUGMENTATION   | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                               | Musculoskeletal                          | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                                | Carelon                                                                                                                                | Change 8/1/2025           |                         |
| 22533               | LAT LUMBAR SPINE FUSION       | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                               | Musculoskeletal                          | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                                | Carelon                                                                                                                                | Change 8/1/2025           |                         |
| 22534               | LAT THOR/LUMB ADDL SEG        | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                               | Musculoskeletal                          | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                                | Carelon                                                                                                                                | Change 8/1/2025           |                         |
| 22551               | NECK SPINE FUSE&REMOV BEL C2  | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                               | Musculoskeletal                          | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                                | Carelon                                                                                                                                | Change 8/1/2025           |                         |
| 22552               | ADDL NECK SPINE FUSION        | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                               | Musculoskeletal                          | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                                | Carelon                                                                                                                                | Change 8/1/2025           |                         |

| CPT and HCPCS Codes | Description of Procedure Code                             | Medical Records Request Information Required        | Clinical Criteria Category | Clinical Criteria Hierarchy                              | Medical Policy Number | Medical Policy Name | Effective and Change Date | Date Posted to Website* |
|---------------------|-----------------------------------------------------------|-----------------------------------------------------|----------------------------|----------------------------------------------------------|-----------------------|---------------------|---------------------------|-------------------------|
| 22554               | NECK SPINE FUSION                                         | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 22558               | LUMBAR SPINE FUSION                                       | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 22585               | ADDITIONAL SPINAL FUSION                                  | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 22595               | NECK SPINAL FUSION                                        | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 22600               | NECK SPINE FUSION                                         | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 22610               | Arthodesis, post or post-lat, single interspace, thoracic | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 22612               | LUMBAR SPINE FUSION                                       | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 22614               | SPINE FUSION EXTRA SEGMENT                                | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 22630               | LUMBAR SPINE FUSION                                       | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 22632               | SPINE FUSION EXTRA SEGMENT                                | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 22633               | LUMBAR SPINE FUSION COMBINED                              | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 22634               | SPINE FUSION EXTRA SEGMENT                                | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 22800               | POST FUSION <6 VERT SEG                                   | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 22802               | POST FUSION 7-12 VERT SEG                                 | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 22804               | POST FUSION 13/> VERT SEG                                 | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 22808               | ANT FUSION 2-3 VERT SEG                                   | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 22810               | ANT FUSION 4-7 VERT SEG                                   | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 22812               | ANT FUSION 8/> VERT SEG                                   | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 22840               | INSERT SPINE FIXATION DEVICE                              | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 22841               | INSERT SPINE FIXATION DEVICE                              | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 22842               | INSERT SPINE FIXATION DEVICE                              | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 22843               | INSERT SPINE FIXATION DEVICE                              | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 22844               | INSERT SPINE FIXATION DEVICE                              | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 22845               | INSERT SPINE FIXATION DEVICE                              | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 22846               | INSERT SPINE FIXATION DEVICE                              | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 22847               | INSERT SPINE FIXATION DEVICE                              | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 22848               | INSERT PELV FIXATION DEVICE                               | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 22853               | INSJ BIOMECHANICAL DEVICE                                 | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 22854               | INSJ BIOMECHANICAL DEVICE                                 | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 22856               | CERV ARTIFIC DISKECTOMY                                   | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 22857               | LUMBAR ARTIF DISKECTOMY                                   | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 22858               | SECOND LEVEL CER DISKECTOMY                               | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |

| CPT and HCPCS Codes | Description of Procedure Code | Medical Records Request Information Required                                                          | Clinical Criteria Category               | Clinical Criteria Hierarchy                              | Medical Policy Number | Medical Policy Name                                                        | Effective and Change Date | Date Posted to Website* |
|---------------------|-------------------------------|-------------------------------------------------------------------------------------------------------|------------------------------------------|----------------------------------------------------------|-----------------------|----------------------------------------------------------------------------|---------------------------|-------------------------|
| 22859               | INSJ BIOMECHANICAL DEVICE     | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 22860               | Tot disc arthrp 2ntsrpc lmr   | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 22861               | REVISE CERV ARTIFIC DISC      | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 22862               | REVISE LUMBAR ARTIF DISC      | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 22864               | REMOVE CERV ARTIF DISC        | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 22867               | INSJ STABLI DEV W/DCMPRN      | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG   | SUR712.029            | Interspinous Distraction (Spacers) and Interlaminar Stabilization Devices  | Added prior to 9/1/2019   |                         |
| 22868               | INSJ STABLI DEV W/DCMPRN      | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG   | SUR712.029            | Interspinous Distraction (Spacers) and Interlaminar Stabilization Devices  | Added prior to 9/1/2019   |                         |
| 22869               | INSJ STABLI DEV W/O DCMPRN    | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG   | SUR712.030            | Interspinous Distraction (Spacers) and Interlaminar Stabilization Devices  | Added prior to 9/1/2019   |                         |
| 22870               | INSJ STABLI DEV W/O DCMPRN    | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG   | SUR712.031            | Interspinous Distraction (Spacers) and Interlaminar Stabilization Devices  | Added prior to 9/1/2019   |                         |
| 22999               | ABDOMEN SURGERY PROCEDURE     | Submit history and physical, documentation of medical necessity including operative report.           | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG   | No Med Policy         | No medical policy                                                          | Added prior to 9/1/2019   |                         |
| 23000               | REMOVAL OF CALCIUM DEPOSITS   | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG   | No Med Policy         | No medical policy                                                          | Added prior to 9/1/2019   |                         |
| 23020               | RELEASE SHOULDER JOINT        | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG   | No Med Policy         | No medical policy                                                          | Added prior to 9/1/2019   |                         |
| 23120               | PARTIAL REMOVAL COLLAR BONE   | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 23130               | REMOVE SHOULDER BONE PART     | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 23410               | REPAIR ROTATOR CUFF ACUTE     | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 23412               | REPAIR ROTATOR CUFF CHRONIC   | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 23415               | RELEASE OF SHOULDER LIGAMENT  | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 23420               | REPAIR OF SHOULDER            | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 23430               | REPAIR BICEPS TENDON          | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 23440               | REMOVE/TRANSPLANT TENDON      | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 23450               | REPAIR SHOULDER CAPSULE       | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 23455               | REPAIR SHOULDER CAPSULE       | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 23460               | REPAIR SHOULDER CAPSULE       | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 23462               | REPAIR SHOULDER CAPSULE       | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 23465               | REPAIR SHOULDER CAPSULE       | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 23466               | REPAIR SHOULDER CAPSULE       | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 23470               | RECONSTRUCT SHOULDER JOINT    | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 23472               | RECONSTRUCT SHOULDER JOINT    | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 23473               | REVIS RECONST SHOULDER JOINT  | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 23474               | REVIS RECONST SHOULDER JOINT  | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 25310               | TRANSPLANT FOREARM TENDON     | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG   | SUR703.001            | Organ and Tissue Transplantation (General Donor and Recipient Information) | Added prior to 9/1/2019   |                         |
| 25312               | TRANSPLANT FOREARM TENDON     | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG   | SUR703.001            | Organ and Tissue Transplantation (General Donor and Recipient Information) | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code | Medical Records Request Information Required                                                          | Clinical Criteria Category               | Clinical Criteria Hierarchy                              | Medical Policy Number | Medical Policy Name                                                        | Effective and Change Date | Date Posted to Website* |
|---------------------|-------------------------------|-------------------------------------------------------------------------------------------------------|------------------------------------------|----------------------------------------------------------|-----------------------|----------------------------------------------------------------------------|---------------------------|-------------------------|
| 26480               | TRANSPLANT HAND TENDON        | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG   | SUR703.001            | Organ and Tissue Transplantation (General Donor and Recipient Information) | Added prior to 9/1/2019   |                         |
| 26483               | TRANSPLANT/GRAFT HAND TENDON  | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG   | SUR703.001            | Organ and Tissue Transplantation (General Donor and Recipient Information) | Added prior to 9/1/2019   |                         |
| 26485               | TRANSPLANT PALM TENDON        | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG   | SUR703.001            | Organ and Tissue Transplantation (General Donor and Recipient Information) | Added prior to 9/1/2019   |                         |
| 26489               | TRANSPLANT/GRAFT PALM TENDON  | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG   | SUR703.001            | Organ and Tissue Transplantation (General Donor and Recipient Information) | Added prior to 9/1/2019   |                         |
| 27096               | INJECT SACROILIAC JOINT       | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 27125               | PARTIAL HIP REPLACEMENT       | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 27130               | TOTAL HIP ARTHROPLASTY        | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 27132               | TOTAL HIP ARTHROPLASTY        | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 27134               | REVISE HIP JOINT REPLACEMENT  | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 27137               | REVISE HIP JOINT REPLACEMENT  | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 27138               | REVISE HIP JOINT REPLACEMENT  | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 27278               | ARTHRODESIS SACROILIAC JOINT  | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 27279               | ARTHRODESIS SACROILIAC JOINT  | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 27280               | FUSION OF SACROILIAC JOINT    | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 27332               | REMOVAL OF KNEE CARTILAGE     | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 27333               | REMOVAL OF KNEE CARTILAGE     | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 27334               | REMOVE KNEE JOINT LINING      | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 27335               | REMOVE KNEE JOINT LINING      | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 27396               | TRANSPLANT OF THIGH TENDON    | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG   | SUR703.001            | Organ and Tissue Transplantation (General Donor and Recipient Information) | Added prior to 9/1/2019   |                         |
| 27397               | TRANSPLANTS OF THIGH TENDONS  | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG   | SUR703.001            | Organ and Tissue Transplantation (General Donor and Recipient Information) | Added prior to 9/1/2019   |                         |
| 27403               | REPAIR OF KNEE CARTILAGE      | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 27405               | REPAIR OF KNEE LIGAMENT       | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 27407               | REPAIR OF KNEE LIGAMENT       | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 27409               | REPAIR OF KNEE LIGAMENTS      | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 27412               | AUTOCHONDROCYTE IMPLANT KNEE  | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 27415               | OSTEOCHONDRAL KNEE ALLOGRAFT  | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 27416               | OSTEOCHONDRAL KNEE AUTOGRAFT  | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 27418               | REPAIR DEGENERATED KNEECAP    | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 27420               | REVISION OF UNSTABLE KNEECAP  | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 27422               | REVISION OF UNSTABLE KNEECAP  | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |
| 27424               | REVISION/REMOVAL OF KNEECAP   | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                    | Change 8/1/2025           |                         |

| CPT and HCPCS Codes | Description of Procedure Code             | Medical Records Request Information Required                                                          | Clinical Criteria Category               | Clinical Criteria Hierarchy                              | Medical Policy Number    | Medical Policy Name                                                                                       | Effective and Change Date | Date Posted to Website* |
|---------------------|-------------------------------------------|-------------------------------------------------------------------------------------------------------|------------------------------------------|----------------------------------------------------------|--------------------------|-----------------------------------------------------------------------------------------------------------|---------------------------|-------------------------|
| 27425               | LAT RETINACULAR RELEASE OPEN              | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                   | Change 8/1/2025           |                         |
| 27427               | RECONSTRUCTION KNEE                       | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                   | Change 8/1/2025           |                         |
| 27428               | RECONSTRUCTION KNEE                       | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                   | Change 8/1/2025           |                         |
| 27429               | RECONSTRUCTION KNEE                       | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                   | Change 8/1/2025           |                         |
| 27430               | REVISION OF THIGH MUSCLES                 | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG   | No Med Policy            | No medical policy                                                                                         | Added prior to 9/1/2019   |                         |
| 27437               | Arthroplasty, patella; without prosthesis | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                   | Change 8/1/2025           |                         |
| 27438               | REVISE KNEECAP WITH IMPLANT               | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                   | Change 8/1/2025           |                         |
| 27440               | REVISION OF KNEE JOINT                    | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                   | Change 8/1/2025           |                         |
| 27441               | REVISION OF KNEE JOINT                    | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                   | Change 8/1/2025           |                         |
| 27442               | REVISION OF KNEE JOINT                    | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                   | Change 8/1/2025           |                         |
| 27443               | REVISION OF KNEE JOINT                    | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                   | Change 8/1/2025           |                         |
| 27445               | REVISION OF KNEE JOINT                    | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                   | Change 8/1/2025           |                         |
| 27446               | REVISION OF KNEE JOINT                    | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                   | Change 8/1/2025           |                         |
| 27447               | TOTAL KNEE ARTHROPLASTY                   | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                   | Change 8/1/2025           |                         |
| 27486               | REVISE/REPLACE KNEE JOINT                 | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                   | Change 8/1/2025           |                         |
| 27487               | REVISE/REPLACE KNEE JOINT                 | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                   | Change 8/1/2025           |                         |
| 27690               | REVISE LOWER LEG TENDON                   | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG   | SUR705.034<br>SUR705.023 | Meniscal Allografts and Other Meniscal Implants<br>Computer-Assisted Navigation for Orthopedic Procedures | Added prior to 9/1/2019   |                         |
| 27691               | REVISE LOWER LEG TENDON                   | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG   | SUR705.034<br>SUR705.023 | Meniscal Allografts and Other Meniscal Implants<br>Computer-Assisted Navigation for Orthopedic Procedures | Added prior to 9/1/2019   |                         |
| 27692               | REVISE ADDITIONAL LEG TENDON              | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG   | SUR705.034<br>SUR705.023 | Meniscal Allografts and Other Meniscal Implants<br>Computer-Assisted Navigation for Orthopedic Procedures | Added prior to 9/1/2019   |                         |
| 28890               | HI ENRGY ESWT PLANTAR FASCIA              | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG   | SUR705.018               | Extracorporeal Shock Wave Therapy for Musculoskeletal Indications and Soft Tissue Injuries                | Added prior to 9/1/2019   |                         |
| 29805               | SHOULDER ARTHROSCOPY DX                   | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                   | Change 8/1/2025           |                         |
| 29806               | SHOULDER ARTHROSCOPY/SURGERY              | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                   | Change 8/1/2025           |                         |
| 29807               | SHOULDER ARTHROSCOPY/SURGERY              | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                   | Change 8/1/2025           |                         |
| 29819               | SHOULDER ARTHROSCOPY/SURGERY              | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                   | Change 8/1/2025           |                         |
| 29820               | SHOULDER ARTHROSCOPY/SURGERY              | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                   | Change 8/1/2025           |                         |
| 29821               | SHOULDER ARTHROSCOPY/SURGERY              | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                   | Change 8/1/2025           |                         |
| 29822               | SHOULDER ARTHROSCOPY/SURGERY              | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                   | Change 8/1/2025           |                         |
| 29823               | SHOULDER ARTHROSCOPY/SURGERY              | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                   | Change 8/1/2025           |                         |
| 29824               | SHOULDER ARTHROSCOPY/SURGERY              | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                   | Change 8/1/2025           |                         |
| 29825               | SHOULDER ARTHROSCOPY/SURGERY              | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                   | Change 8/1/2025           |                         |
| 29826               | SHOULDER ARTHROSCOPY/SURGERY              | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                   | Change 8/1/2025           |                         |
| 29827               | ARTHROSCOP ROTATOR CUFF REPR              | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                   | Change 8/1/2025           |                         |

| CPT and HCPCS Codes | Description of Procedure Code | Medical Records Request Information Required                                                | Clinical Criteria Category               | Clinical Criteria Hierarchy                              | Medical Policy Number    | Medical Policy Name                                                                                               | Effective and Change Date | Date Posted to Website* |
|---------------------|-------------------------------|---------------------------------------------------------------------------------------------|------------------------------------------|----------------------------------------------------------|--------------------------|-------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------|
| 29828               | ARTHROSCOPY BICEPS TENODESIS  | Carelon-https://providerportal.com/ or 866-455-8415                                         | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                           | Change 8/1/2025           |                         |
| 29860               | HIP ARTHROSCOPY DX            | Carelon-https://providerportal.com/ or 866-455-8415                                         | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                           | Change 8/1/2025           |                         |
| 29861               | HIP ARTHRO W/FB REMOVAL       | Carelon-https://providerportal.com/ or 866-455-8415                                         | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                           | Change 8/1/2025           |                         |
| 29862               | HIP ARTHRO W/DEBRIDEMENT      | Carelon-https://providerportal.com/ or 866-455-8415                                         | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                           | Change 8/1/2025           |                         |
| 29863               | HIP ARTHRO W/SYNOVECTOMY      | Carelon-https://providerportal.com/ or 866-455-8415                                         | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                           | Change 8/1/2025           |                         |
| 29866               | AUTGRFT IMPLNT KNEE W/SCOPE   | Carelon-https://providerportal.com/ or 866-455-8415                                         | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                           | Change 8/1/2025           |                         |
| 29867               | ALLGRFT IMPLNT KNEE W/SCOPE   | Carelon-https://providerportal.com/ or 866-455-8415                                         | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                           | Change 8/1/2025           |                         |
| 29868               | MENISCAL TRNSPL KNEE W/SCPE   | Carelon-https://providerportal.com/ or 866-455-8415                                         | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                           | Change 8/1/2025           |                         |
| 29870               | KNEE ARTHROSCOPY DX           | Carelon-https://providerportal.com/ or 866-455-8415                                         | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                           | Change 8/1/2025           |                         |
| 29871               | KNEE ARTHROSCOPY/DRAINAGE     | Carelon-https://providerportal.com/ or 866-455-8415                                         | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                           | Change 8/1/2025           |                         |
| 29873               | KNEE ARTHROSCOPY/SURGERY      | Carelon-https://providerportal.com/ or 866-455-8415                                         | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                           | Change 8/1/2025           |                         |
| 29874               | KNEE ARTHROSCOPY/SURGERY      | Carelon-https://providerportal.com/ or 866-455-8415                                         | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                           | Change 8/1/2025           |                         |
| 29875               | KNEE ARTHROSCOPY/SURGERY      | Carelon-https://providerportal.com/ or 866-455-8415                                         | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                           | Change 8/1/2025           |                         |
| 29876               | KNEE ARTHROSCOPY/SURGERY      | Carelon-https://providerportal.com/ or 866-455-8415                                         | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                           | Change 8/1/2025           |                         |
| 29877               | KNEE ARTHROSCOPY/SURGERY      | Carelon-https://providerportal.com/ or 866-455-8415                                         | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                           | Change 8/1/2025           |                         |
| 29879               | KNEE ARTHROSCOPY/SURGERY      | Carelon-https://providerportal.com/ or 866-455-8415                                         | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                           | Change 8/1/2025           |                         |
| 29880               | KNEE ARTHROSCOPY/SURGERY      | Carelon-https://providerportal.com/ or 866-455-8415                                         | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                           | Change 8/1/2025           |                         |
| 29881               | KNEE ARTHROSCOPY/SURGERY      | Carelon-https://providerportal.com/ or 866-455-8415                                         | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                           | Change 8/1/2025           |                         |
| 29882               | KNEE ARTHROSCOPY/SURGERY      | Carelon-https://providerportal.com/ or 866-455-8415                                         | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                           | Change 8/1/2025           |                         |
| 29883               | KNEE ARTHROSCOPY/SURGERY      | Carelon-https://providerportal.com/ or 866-455-8415                                         | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                           | Change 8/1/2025           |                         |
| 29884               | KNEE ARTHROSCOPY/SURGERY      | Carelon-https://providerportal.com/ or 866-455-8415                                         | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                           | Change 8/1/2025           |                         |
| 29885               | KNEE ARTHROSCOPY/SURGERY      | Carelon-https://providerportal.com/ or 866-455-8415                                         | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                           | Change 8/1/2025           |                         |
| 29886               | KNEE ARTHROSCOPY/SURGERY      | Carelon-https://providerportal.com/ or 866-455-8415                                         | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                           | Change 8/1/2025           |                         |
| 29887               | KNEE ARTHROSCOPY/SURGERY      | Carelon-https://providerportal.com/ or 866-455-8415                                         | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                           | Change 8/1/2025           |                         |
| 29888               | KNEE ARTHROSCOPY/SURGERY      | Carelon-https://providerportal.com/ or 866-455-8415                                         | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                           | Change 8/1/2025           |                         |
| 29889               | KNEE ARTHROSCOPY/SURGERY      | Carelon-https://providerportal.com/ or 866-455-8415                                         | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                           | Change 8/1/2025           |                         |
| 29914               | HIP ARTHRO W/FEMOROPLASTY     | Carelon-https://providerportal.com/ or 866-455-8415                                         | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                           | Change 8/1/2025           |                         |
| 29915               | HIP ARTHRO ACETABULOPLASTY    | Carelon-https://providerportal.com/ or 866-455-8415                                         | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                           | Change 8/1/2025           |                         |
| 29916               | HIP ARTHRO W/LABRAL REPAIR    | Carelon-https://providerportal.com/ or 866-455-8415                                         | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon                  | Carelon                                                                                                           | Change 8/1/2025           |                         |
| 30400               | RECONSTRUCTION OF NOSE        | Submit history and physical, documentation of medical necessity including operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG   | SUR717.001<br>SUR706.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br><u>Nasal and Sinus Surgery</u> | Added prior to 9/1/2019   |                         |
| 30410               | RECONSTRUCTION OF NOSE        | Submit history and physical, documentation of medical necessity including operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG   | SUR717.001<br>SUR706.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br><u>Nasal and Sinus Surgery</u> | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code    | Medical Records Request Information Required                                                                                                            | Clinical Criteria Category               | Clinical Criteria Hierarchy                                                                                                     | Medical Policy Number    | Medical Policy Name                                                                                        | Effective and Change Date | Date Posted to Website* |
|---------------------|----------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|--------------------------|------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------|
| 30420               | RECONSTRUCTION OF NOSE           | Submit history and physical, documentation of medical necessity including operative report.                                                             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SUR717.001<br>SUR706.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Nasal and Sinus Surgery | Added prior to 9/1/2019   |                         |
| 30430               | REVISION OF NOSE                 | Submit history and physical, documentation of medical necessity including operative report.                                                             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SUR717.001<br>SUR706.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Nasal and Sinus Surgery | Added prior to 9/1/2019   |                         |
| 30435               | REVISION OF NOSE                 | Submit history and physical, documentation of medical necessity including operative report.                                                             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SUR717.001<br>SUR706.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Nasal and Sinus Surgery | Added prior to 9/1/2019   |                         |
| 30450               | REVISION OF NOSE                 | Submit history and physical, documentation of medical necessity including operative report.                                                             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SUR717.001<br>SUR706.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Nasal and Sinus Surgery | Added prior to 9/1/2019   |                         |
| 30460               | REVISION OF NOSE                 | Submit history and physical, documentation of medical necessity including operative report.                                                             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SUR717.001<br>SUR706.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Nasal and Sinus Surgery | Added prior to 9/1/2019   |                         |
| 30462               | REVISION OF NOSE                 | Submit history and physical, documentation of medical necessity including operative report.                                                             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SUR717.001<br>SUR706.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Nasal and Sinus Surgery | Added prior to 9/1/2019   |                         |
| 30520               | REPAIR OF NASAL SEPTUM           | Submit history and physical, documentation of medical necessity including operative report.                                                             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SUR712.031<br>SUR706.001 | Surgical Deactivation of Headache Trigger Sites<br>Nasal and Sinus Surgery                                 | Added prior to 9/1/2019   |                         |
| 31540               | LARYNGOSCOPY W/EXC OF TUMOR      | Submit history and physical, documentation of medical necessity including operative report.                                                             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SUR717.001               | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                            | Added 1/1/23              |                         |
| 31541               | LARYNGOSCOPY W/TUMR EXC + SCOPE  | Submit history and physical, documentation of medical necessity including operative report.                                                             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SUR717.001               | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                            | Added 1/1/23              |                         |
| 31545               | REMOVE VC LESION W/SCOPE         | Submit history and physical, documentation of medical necessity including operative report.                                                             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SUR717.001               | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                            | Added 1/1/23              |                         |
| 31546               | REMOVE VC LESION SCOPE/GRAFT     | Submit history and physical, documentation of medical necessity including operative report.                                                             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | PSY301.011               | Neurofeedback                                                                                              | Added 1/1/23              |                         |
| 31551               | LARYNGOPLASTY LARYNGEAL STEN     | Submit history and physical, documentation of medical necessity including operative report.                                                             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SUR717.001               | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                            | Added 1/1/23              |                         |
| 31552               | LARYNGOPLASTY LARYNGEAL STEN     | Submit history and physical, documentation of medical necessity including operative report.                                                             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SUR717.001               | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                            | Added 1/1/23              |                         |
| 31553               | LARYNGOPLASTY LARYNGEAL STEN     | Submit history and physical, documentation of medical necessity including operative report.                                                             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SUR717.001               | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                            | Added 1/1/23              |                         |
| 31554               | LARYNGOPLASTY LARYNGEAL STEN     | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                                   | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SUR717.001               | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                            | Added 1/1/23              |                         |
| 31560               | LARYNGOSCOPY W/ARYTENOIDECTOMY   | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                                   | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SUR717.001               | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                            | Added 1/1/23              |                         |
| 31561               | LARYNGOSCOPY REMOVE CART + SCOPE | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                                   | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SUR717.001               | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                            | Added 1/1/23              |                         |
| 31570               | LARYNGOSCOPY W/VC INJ            | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                                   | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | RX501.019,               | Botulinum Toxin                                                                                            | Added 1/1/23              |                         |
| 31571               | LARYNGOSCOPY W/VC INJ + SCOPE    | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                                   | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | RX501.019,               | Botulinum Toxin                                                                                            | Added 1/1/23              |                         |
| 31575               | DIAGNOSTIC LARYNGOSCOPY          | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                                   | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | No Med Policy            | No medical policy                                                                                          | Added prior to 9/1/2019   |                         |
| 31579               | LARYNGOSCOPY TELESCOPIC          | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                                   | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | No Med Policy            | No medical policy                                                                                          | Added prior to 9/1/2019   |                         |
| 31580               | LARYNGOPLASTY LARYNGEAL WEB      | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                                   | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SUR717.001               | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                            | Added 1/1/23              |                         |
| 31584               | LARYNGOPLASTY FX RDCTJ FIX       | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                                   | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SUR717.001               | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                            | Added 1/1/23              |                         |
| 31587               | LARYNGOPLASTY CRICOID SPLIT      | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                                   | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SUR717.001               | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                            | Added 1/1/23              |                         |
| 31643               | DIAG BRONCHOSCOPE/CATHETER       | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                                          | Radiation Therapy                        | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                                    | Change 8/1/2025           |                         |
| 31899               | AIRWAYS SURGICAL PROCEDURE       | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                                   | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SUR717.001               | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                            | Added 1/1/23              |                         |
| 32701               | THORAX STEREO RAD TARGET W/TX    | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                                          | Radiation Therapy                        | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                                    | Change 8/1/2025           |                         |
| 32851               | LUNG TRANSPLANT SINGLE           | If transplant approval on record: Date of transplant<br>If no transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                                                                          | SUR703.010               | Lung and Lobar Lung Transplant                                                                             | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code | Medical Records Request Information Required                                                                                                            | Clinical Criteria Category               | Clinical Criteria Hierarchy                                                         | Medical Policy Number | Medical Policy Name                                         | Effective and Change Date | Date Posted to Website* |
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| 32852               | LUNG TRANSPLANT WITH BYPASS   | If transplant approval on record: Date of transplant<br>If no transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                              | SUR703.010            | Lung and Lobar Lung Transplant                              | Added prior to 9/1/2019   |                         |
| 32853               | LUNG TRANSPLANT DOUBLE        | If transplant approval on record: Date of transplant<br>If no transplant approval: history and physical, transplant evaluation, and date of transplant. | Transplant                               | Illinois Medicaid Provider Manual, Medical Policy, MCG                              | SUR703.010            | Lung and Lobar Lung Transplant                              | Added prior to 9/1/2019   |                         |
| 32854               | LUNG TRANSPLANT WITH BYPASS   | If transplant approval on record: Date of transplant<br>If no transplant approval: history and physical, transplant evaluation, and date of transplant. | Transplant                               | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | SUR703.010            | Lung and Lobar Lung Transplant                              | Added prior to 9/1/2019   |                         |
| 33405               | REPLACEMENT AORTIC VALVE OPN  | Letter of medical necessity, including condition being treated.                                                                                         | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                              | SUR707.028            | Transcatheter Aortic-Valve Implantation for Aortic Stenosis | Added prior to 9/1/2019   |                         |
| 33430               | REPLACEMENT OF MITRAL VALVE   | Letter of medical necessity, including condition being treated.                                                                                         | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                              | SUR707.025            | Transcatheter Mitral Valve Procedures                       | Added prior to 9/1/2019   |                         |
| 33935               | TRANSPLANTATION HEART/LUNG    | If transplant approval on record: Date of transplant<br>If no transplant approval: history and physical, transplant evaluation, and date of transplant. | Transplant                               | Illinois Medicaid Provider Manual, Medical Policy, MCG                              | SUR703.006            | Heart/Lung Transplant                                       | Added prior to 9/1/2019   |                         |
| 33945               | TRANSPLANTATION OF HEART      | If transplant approval on record: Date of transplant<br>If no transplant approval: history and physical, transplant evaluation, and date of transplant. | Transplant                               | Illinois Medicaid Provider Manual, Medical Policy, MCG                              | SUR703.005            | Heart Transplant                                            | Added prior to 9/1/2019   |                         |
| 35879               | REVISE GRAFT W/VEIN           | If transplant approval on record: Date of transplant<br>If no transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                              | SUR703.005            | Heart Transplant                                            | Added prior to 9/1/2019   |                         |
| 36468               | NIX SCLRSNT SPIDER VEINS      | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                                   | Outpatient Medical and surgical services | Medicare NCD/LCD Guidelines , MCG, BCBS Medical Policy                              | SUR707.016            | Varicose Vein Management                                    | Added prior to 9/1/2019   |                         |
| 36469               | NIX SCLRSNT SPIDER VEINS      | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                                   | Outpatient Medical and surgical services | Medicare NCD/LCD Guidelines , MCG, BCBS Medical Policy                              | SUR707.016            | Varicose Vein Management                                    | Added prior to 9/1/2019   |                         |
| 36470               | NIX SCLRSNT 1 INCMPTNT VEIN   | Pre-operative evaluation, history and physical including functional impairment, and operative report.                                                   | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                              | SUR707.016            | Varicose Vein Management                                    | Added prior to 9/1/2019   |                         |
| 37700               | REVISE LEG VEIN               | Pre-operative evaluation, history and physical and operative report.                                                                                    | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                              | SUR707.016            | Varicose Vein Management                                    | Added prior to 9/1/2019   |                         |
| 37718               | LIGATE/STRIP SHORT LEG VEIN   | Pre-operative evaluation, history and physical and operative report.                                                                                    | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                              | SUR707.016            | Varicose Vein Management                                    | Added prior to 9/1/2019   |                         |
| 37722               | LIGATE/STRIP LONG LEG VEIN    | Pre-operative evaluation, history and physical and operative report.                                                                                    | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                              | SUR707.016            | Varicose Vein Management                                    | Added prior to 9/1/2019   |                         |
| 37735               | REMOVAL OF LEG VEINS/LESION   | Pre-operative evaluation, history and physical and operative report.                                                                                    | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                              | SUR707.016            | Varicose Vein Management                                    | Added prior to 9/1/2019   |                         |
| 37760               | LIGATE LEG VEINS RADICAL      | History and physical and operative report.                                                                                                              | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                              | SUR707.016            | Varicose Vein Management                                    | Added prior to 9/1/2019   |                         |
| 37761               | LIGATE LEG VEINS OPEN         | History and physical and operative report.                                                                                                              | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                              | SUR707.016            | Varicose Vein Management                                    | Added prior to 9/1/2019   |                         |
| 37780               | REVISION OF LEG VEIN          | Pre-operative evaluation, history and physical and operative report.                                                                                    | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                              | SUR707.016            | Varicose Vein Management                                    | Added prior to 9/1/2019   |                         |
| 37785               | LIGATE/DIVIDE/EXCISE VEIN     | Pre-operative evaluation, history and physical and operative report.                                                                                    | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG                              | SUR707.016            | Varicose Vein Management                                    | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code | Medical Records Request Information Required                                                                                                            | Clinical Criteria Category               | Clinical Criteria Hierarchy                            | Medical Policy Number                                                                                                                                                                                                                                                                              | Medical Policy Name                                                                                                                                                                                                                                                   | Effective and Change Date | Date Posted to Website* |
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| 38204               | BL DONOR SEARCH MANAGEMENT    | If transplant approval on record: Date of transplant<br>If no transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Medicare NCD/LCD Guidelines , MCG, BCBS Medical Policy | SUR703.037<br>SUR703.002<br>SUR703.043<br>SUR703.047<br>SUR703.036<br>SUR703.038<br>SUR703.039<br>SUR703.029<br>SUR703.041<br>SUR703.034<br>SUR703.033<br>SUR703.040<br>SUR703.042<br>SUR703.035<br>SUR703.032<br>SUR703.031<br>SUR703.030<br>SUR703.046<br>SUR703.044<br>SUR703.050<br>SUR703.045 | Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML)<br>Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information)<br>Hematopoietic Cell Transplantation as a Treatm | Added prior to 9/1/2019   |                         |
| 38205               | HARVEST ALLOGENEIC STEM CELL  | If transplant approval on record: Date of transplant<br>If no transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, Medical Policy, MCG | SUR703.037<br>SUR703.002<br>SUR703.043<br>SUR703.047<br>SUR703.036<br>SUR703.038<br>SUR703.039<br>SUR703.029<br>SUR703.041<br>SUR703.034<br>SUR703.033<br>SUR703.040<br>SUR703.042<br>SUR703.035<br>SUR703.032<br>SUR703.031<br>SUR703.030<br>SUR703.046<br>SUR703.044<br>SUR703.050<br>SUR703.045 | Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML)<br>Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information)<br>Hematopoietic Cell Transplantation as a Treatm | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code | Medical Records Request Information Required                                                                                                            | Clinical Criteria Category               | Clinical Criteria Hierarchy                                 | Medical Policy Number                                                                                                                                                                                                                                                                              | Medical Policy Name                                                                                                                                                                                                                                                   | Effective and Change Date | Date Posted to Website* |
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| 38206               | HARVEST AUTO STEM CELLS       | If transplant approval on record: Date of transplant<br>If no transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.037<br>SUR703.002<br>SUR703.043<br>SUR703.047<br>SUR703.036<br>SUR703.038<br>SUR703.039<br>SUR703.029<br>SUR703.041<br>SUR703.034<br>SUR703.033<br>SUR703.040<br>SUR703.042<br>SUR703.035<br>SUR703.032<br>SUR703.031<br>SUR703.030<br>SUR703.046<br>SUR703.044<br>SUR703.050<br>SUR703.045 | Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML)<br>Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information)<br>Hematopoietic Cell Transplantation as a Treatm | Added prior to 9/1/2019   |                         |
| 38207               | CRYOPRESERVE STEM CELLS       | If transplant approval on record: Date of transplant<br>If no transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.037<br>SUR703.002<br>SUR703.043<br>SUR703.047<br>SUR703.036<br>SUR703.038<br>SUR703.039<br>SUR703.029<br>SUR703.041<br>SUR703.034<br>SUR703.033<br>SUR703.040<br>SUR703.042<br>SUR703.035<br>SUR703.032<br>SUR703.031<br>SUR703.030<br>SUR703.046<br>SUR703.044<br>SUR703.050               | Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML)<br>Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information)<br>Hematopoietic Cell Transplantation as a Treatm | Added prior to 9/1/2019   |                         |
| 38208               | THAW PRESERVED STEM CELLS     | If transplant approval on record: Date of transplant<br>If no transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.037<br>SUR703.002<br>SUR703.043<br>SUR703.047<br>SUR703.036<br>SUR703.038<br>SUR703.039<br>SUR703.029<br>SUR703.041<br>SUR703.034<br>SUR703.033<br>SUR703.040<br>SUR703.042<br>SUR703.035<br>SUR703.032<br>SUR703.031<br>SUR703.030<br>SUR703.046<br>SUR703.044<br>SUR703.050               | Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML)<br>Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information)<br>Hematopoietic Cell Transplantation as a Treatm | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code | Medical Records Request Information Required                                                                                                            | Clinical Criteria Category               | Clinical Criteria Hierarchy                                 | Medical Policy Number                                                                                                                                                                                                                                                                | Medical Policy Name                                                                                                                                                                                                                                                   | Effective and Change Date | Date Posted to Website* |
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| 38209               | WASH HARVEST STEM CELLS       | If transplant approval on record: Date of transplant<br>If no transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.037<br>SUR703.002<br>SUR703.043<br>SUR703.047<br>SUR703.036<br>SUR703.038<br>SUR703.039<br>SUR703.029<br>SUR703.041<br>SUR703.034<br>SUR703.033<br>SUR703.040<br>SUR703.042<br>SUR703.035<br>SUR703.032<br>SUR703.031<br>SUR703.030<br>SUR703.046<br>SUR703.044<br>SUR703.050 | Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML)<br>Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information)<br>Hematopoietic Cell Transplantation as a Treatm | Added prior to 9/1/2019   |                         |
| 38210               | T-CELL DEPLETION OF HARVEST   | If transplant approval on record: Date of transplant<br>If no transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.037<br>SUR703.002<br>SUR703.043<br>SUR703.047<br>SUR703.036<br>SUR703.038<br>SUR703.039<br>SUR703.029<br>SUR703.041<br>SUR703.034<br>SUR703.033<br>SUR703.040<br>SUR703.042<br>SUR703.035<br>SUR703.032<br>SUR703.031<br>SUR703.030<br>SUR703.046<br>SUR703.044<br>SUR703.050 | Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML)<br>Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information)<br>Hematopoietic Cell Transplantation as a Treatm | Added prior to 9/1/2019   |                         |
| 38211               | TUMOR CELL DEplete OF HARVST  | If transplant approval on record: Date of transplant<br>If no transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.037<br>SUR703.002<br>SUR703.043<br>SUR703.047<br>SUR703.036<br>SUR703.038<br>SUR703.039<br>SUR703.029<br>SUR703.041<br>SUR703.034<br>SUR703.033<br>SUR703.040<br>SUR703.042<br>SUR703.035<br>SUR703.032<br>SUR703.031<br>SUR703.030<br>SUR703.046<br>SUR703.044<br>SUR703.050 | Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML)<br>Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information)<br>Hematopoietic Cell Transplantation as a Treatm | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code | Medical Records Request Information Required                                                                                                            | Clinical Criteria Category               | Clinical Criteria Hierarchy                                 | Medical Policy Number                                                                                                                                                                                                                                                                | Medical Policy Name                                                                                                                                                                                                                                                   | Effective and Change Date | Date Posted to Website* |
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| 38212               | RBC DEPLETION OF HARVEST      | If transplant approval on record: Date of transplant<br>If no transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.037<br>SUR703.002<br>SUR703.043<br>SUR703.047<br>SUR703.036<br>SUR703.038<br>SUR703.039<br>SUR703.029<br>SUR703.041<br>SUR703.034<br>SUR703.033<br>SUR703.040<br>SUR703.042<br>SUR703.035<br>SUR703.032<br>SUR703.031<br>SUR703.030<br>SUR703.046<br>SUR703.044<br>SUR703.050 | Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML)<br>Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information)<br>Hematopoietic Cell Transplantation as a Treatm | Added prior to 9/1/2019   |                         |
| 38213               | PLATELET DEplete OF HARVEST   | If transplant approval on record: Date of transplant<br>If no transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.037<br>SUR703.002<br>SUR703.043<br>SUR703.047<br>SUR703.036<br>SUR703.038<br>SUR703.039<br>SUR703.029<br>SUR703.041<br>SUR703.034<br>SUR703.033<br>SUR703.040<br>SUR703.042<br>SUR703.035<br>SUR703.032<br>SUR703.031<br>SUR703.030<br>SUR703.046<br>SUR703.044<br>SUR703.050 | Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML)<br>Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information)<br>Hematopoietic Cell Transplantation as a Treatm | Added prior to 9/1/2019   |                         |
| 38214               | VOLUME DEplete OF HARVEST     | If transplant approval on record: Date of transplant<br>If no transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.037<br>SUR703.002<br>SUR703.043<br>SUR703.047<br>SUR703.036<br>SUR703.038<br>SUR703.039<br>SUR703.029<br>SUR703.041<br>SUR703.034<br>SUR703.033<br>SUR703.040<br>SUR703.042<br>SUR703.035<br>SUR703.032<br>SUR703.031<br>SUR703.030<br>SUR703.046<br>SUR703.044<br>SUR703.050 | Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML)<br>Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information)<br>Hematopoietic Cell Transplantation as a Treatm | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code | Medical Records Request Information Required                                                                                                            | Clinical Criteria Category               | Clinical Criteria Hierarchy                                 | Medical Policy Number                                                                                                                                                                                                                                                                              | Medical Policy Name                                                                                                                                                                                                                                                      | Effective and Change Date | Date Posted to Website* |
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| 38215               | HARVEST STEM CELL CONCENTRATE | If transplant approval on record: Date of transplant<br>If no transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.037<br>SUR703.002<br>SUR703.043<br>SUR703.047<br>SUR703.036<br>SUR703.038<br>SUR703.039<br>SUR703.029<br>SUR703.041<br>SUR703.034<br>SUR703.033<br>SUR703.040<br>SUR703.042<br>SUR703.035<br>SUR703.032<br>SUR703.031<br>SUR703.030<br>SUR703.046<br>SUR703.044<br>SUR703.050<br>SUR703.045 | Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML)<br>Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information)<br>Hematopoietic Cell Transplantation as a Treatment | Added prior to 9/1/2019   |                         |
| 38230               | BONE MARROW HARVEST ALLOGEN   | If transplant approval on record: Date of transplant<br>If no transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.037<br>SUR703.002<br>SUR703.043<br>SUR703.047<br>SUR703.036<br>SUR703.038<br>SUR703.039<br>SUR703.029<br>SUR703.041<br>SUR703.034<br>SUR703.033<br>SUR703.040<br>SUR703.042<br>SUR703.035<br>SUR703.032<br>SUR703.031<br>SUR703.030<br>SUR703.046<br>SUR703.044<br>SUR703.050<br>SUR703.045 | Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML)<br>Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information)<br>Hematopoietic Cell Transplantation as a Treatment | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code | Medical Records Request Information Required                                                                                                            | Clinical Criteria Category               | Clinical Criteria Hierarchy                                 | Medical Policy Number                                                                                                                                                                                                                                                                              | Medical Policy Name                                                                                                                                                                                                                                                   | Effective and Change Date | Date Posted to Website* |
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| 38232               | BONE MARROW HARVEST AUTOLOG   | If transplant approval on record: Date of transplant<br>If no transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.037<br>SUR703.002<br>SUR703.043<br>SUR703.047<br>SUR703.036<br>SUR703.038<br>SUR703.039<br>SUR703.029<br>SUR703.041<br>SUR703.034<br>SUR703.033<br>SUR703.040<br>SUR703.042<br>SUR703.035<br>SUR703.032<br>SUR703.031<br>SUR703.030<br>SUR703.046<br>SUR703.044<br>SUR703.050<br>SUR703.045 | Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML)<br>Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information)<br>Hematopoietic Cell Transplantation as a Treatm | Added prior to 9/1/2019   |                         |
| 38240               | TRANSPLT ALLO HCT/DONOR       | If transplant approval on record: Date of transplant<br>If no transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.037<br>SUR703.002<br>SUR703.043<br>SUR703.047<br>SUR703.036<br>SUR703.038<br>SUR703.039<br>SUR703.029<br>SUR703.041<br>SUR703.034<br>SUR703.033<br>SUR703.040<br>SUR703.042<br>SUR703.035<br>SUR703.032<br>SUR703.031<br>SUR703.030<br>SUR703.046<br>SUR703.044<br>SUR703.050<br>SUR703.045 | Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML)<br>Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information)<br>Hematopoietic Cell Transplantation as a Treatm | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code | Medical Records Request Information Required                                                                                                            | Clinical Criteria Category               | Clinical Criteria Hierarchy                                                                                                     | Medical Policy Number                                                                                                                                                                                                                                                                              | Medical Policy Name                                                                                                                                                                                                                                                   | Effective and Change Date | Date Posted to Website* |
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| 38241               | TRANSPLT AUTOL HCT/DONOR      | If transplant approval on record: Date of transplant<br>If no transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR703.037<br>SUR703.002<br>SUR703.043<br>SUR703.047<br>SUR703.036<br>SUR703.038<br>SUR703.039<br>SUR703.029<br>SUR703.041<br>SUR703.034<br>SUR703.033<br>SUR703.040<br>SUR703.042<br>SUR703.035<br>SUR703.032<br>SUR703.031<br>SUR703.030<br>SUR703.046<br>SUR703.044<br>SUR703.050<br>SUR703.045 | Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML)<br>Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information)<br>Hematopoietic Cell Transplantation as a Treatm | Added prior to 9/1/2019   |                         |
| 38242               | TRANSPLT ALLO LYMPHOCYTES     | If transplant approval on record: Date of transplant<br>If no transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR703.037<br>SUR703.002<br>SUR703.043<br>SUR703.047<br>SUR703.036<br>SUR703.038<br>SUR703.039<br>SUR703.029<br>SUR703.041<br>SUR703.034<br>SUR703.033<br>SUR703.040<br>SUR703.042<br>SUR703.035<br>SUR703.032<br>SUR703.031<br>SUR703.030<br>SUR703.046<br>SUR703.044<br>SUR703.050               | Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML)<br>Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information)<br>Hematopoietic Cell Transplantation as a Treatm | Added prior to 9/1/2019   |                         |
| 40530               | PARTIAL REMOVAL OF LIP        | History and physical and operative report.                                                                                                              | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR717.001                                                                                                                                                                                                                                                                                         | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                                                                                                                                                       | Added 1/1/23              |                         |
| 41019               | PLACE NEEDLES H&N FOR RT      | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                                          | Radiation Therapy                        | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                                                                                                                                                                                                                                                                                            | Carelon                                                                                                                                                                                                                                                               | Change 8/1/2025           |                         |
| 43112               | ESPHG TOT W/THRCM             | History and physical and operative report.                                                                                                              | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR709.033                                                                                                                                                                                                                                                                                         | Endoscopic Radiofrequency Ablation or Cryoablation for Barrett Esophagus                                                                                                                                                                                              | Added prior to 9/1/2019   |                         |
| 43121               | PARTIAL REMOVAL OF ESOPHAGUS  | History and physical and operative report.                                                                                                              | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR709.033                                                                                                                                                                                                                                                                                         | Endoscopic Radiofrequency Ablation or Cryoablation for Barrett Esophagus                                                                                                                                                                                              | Added prior to 9/1/2019   |                         |
| 43122               | PARTIAL REMOVAL OF ESOPHAGUS  | History and physical and operative report.                                                                                                              | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR709.033                                                                                                                                                                                                                                                                                         | Endoscopic Radiofrequency Ablation or Cryoablation for Barrett Esophagus                                                                                                                                                                                              | Added prior to 9/1/2019   |                         |
| 43360               | GASTROINTESTINAL REPAIR       | History and physical and operative report.                                                                                                              | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | No Med Policy                                                                                                                                                                                                                                                                                      | No medical policy                                                                                                                                                                                                                                                     | Added prior to 9/1/2019   |                         |
| 43633               | REMOVAL OF STOMACH PARTIAL    | History and physical and operative report.                                                                                                              | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR716.003                                                                                                                                                                                                                                                                                         | Bariatric Surgery                                                                                                                                                                                                                                                     | Added prior to 9/1/2019   |                         |
| 43644               | LAP GASTRIC BYPASS/ROUX-EN-Y  | History and physical, nutritional evaluation, psychological evaluation, weight loss attempts, social supports.                                          | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR716.003                                                                                                                                                                                                                                                                                         | Bariatric Surgery                                                                                                                                                                                                                                                     | Added prior to 9/1/2019   |                         |
| 43645               | LAP GASTR BYPASS INCL SMILL   | History and physical, nutritional evaluation, psychological evaluation, weight loss attempts, social supports.                                          | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR716.003                                                                                                                                                                                                                                                                                         | Bariatric Surgery                                                                                                                                                                                                                                                     | Added prior to 9/1/2019   |                         |
| 43659               | LAPAROSCOPE PROC STOM         | Letter of medical necessity, including condition being treated.                                                                                         | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR716.003                                                                                                                                                                                                                                                                                         | Bariatric Surgery                                                                                                                                                                                                                                                     | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code | Medical Records Request Information Required                                                                                                            | Clinical Criteria Category               | Clinical Criteria Hierarchy                                 | Medical Policy Number    | Medical Policy Name                                                               | Effective and Change Date | Date Posted to Website* |
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| 43770               | LAP PLACE GASTR ADJ DEVICE    | History and physical, nutritional evaluation, psychological evaluation, weight loss attempts, social supports.                                          | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR716.003               | Bariatric Surgery                                                                 | Added prior to 9/1/2019   |                         |
| 43771               | LAP REVISE GASTR ADJ DEVICE   | History and physical, nutritional evaluation, psychological evaluation, weight loss attempts, social supports.                                          | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR716.003               | Bariatric Surgery                                                                 | Added prior to 9/1/2019   |                         |
| 43772               | LAP RMVL GASTR ADJ DEVICE     | History and physical, nutritional evaluation, psychological evaluation, weight loss attempts, social supports.                                          | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR716.003               | Bariatric Surgery                                                                 | Added prior to 9/1/2019   |                         |
| 43773               | LAP REPLACE GASTR ADJ DEVICE  | History and physical, nutritional evaluation, psychological evaluation, weight loss attempts, social supports.                                          | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR716.003               | Bariatric Surgery                                                                 | Added prior to 9/1/2019   |                         |
| 43774               | LAP RMVL GASTR ADJ ALL PARTS  | History and physical, nutritional evaluation, psychological evaluation, weight loss attempts, social supports.                                          | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR716.003               | Bariatric Surgery                                                                 | Added prior to 9/1/2019   |                         |
| 43775               | LAP SLEEVE GASTRECTOMY        | History and physical, nutritional evaluation, psychological evaluation, weight loss attempts, social supports.                                          | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR716.003               | Bariatric Surgery                                                                 | Added prior to 9/1/2019   |                         |
| 43800               | RECONSTRUCTION OF PYLORUS     | History and physical, nutritional evaluation, psychological evaluation, weight loss attempts, social supports.                                          | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | No Med Policy            | No medical policy                                                                 | Added prior to 9/1/2019   |                         |
| 43842               | V-BAND GASTROPLASTY           | History and physical, nutritional evaluation, psychological evaluation, weight loss attempts, social supports.                                          | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR716.003               | Bariatric Surgery                                                                 | Added prior to 9/1/2019   |                         |
| 43843               | GASTROPLASTY W/O V-BAND       | History and physical, nutritional evaluation, psychological evaluation, weight loss attempts, social supports.                                          | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR716.003               | Bariatric Surgery                                                                 | Added prior to 9/1/2019   |                         |
| 43845               | GASTROPLASTY DUODENAL SWITCH  | History and physical, nutritional evaluation, psychological evaluation, weight loss attempts, social supports.                                          | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR716.003               | Bariatric Surgery                                                                 | Added prior to 9/1/2019   |                         |
| 43846               | GASTRIC BYPASS FOR OBESITY    | History and physical, nutritional evaluation, psychological evaluation, weight loss attempts, social supports.                                          | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR716.003               | Bariatric Surgery                                                                 | Added prior to 9/1/2019   |                         |
| 43847               | GASTRIC BYPASS INCL SMALL I   | History and physical, nutritional evaluation, psychological evaluation, weight loss attempts, social supports.                                          | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR716.003               | Bariatric Surgery                                                                 | Added prior to 9/1/2019   |                         |
| 43848               | REVISION GASTROPLASTY         | History and physical, nutritional evaluation, psychological evaluation, weight loss attempts, social supports.                                          | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR716.003               | Bariatric Surgery                                                                 | Added prior to 9/1/2019   |                         |
| 43886               | REVISE GASTRIC PORT OPEN      | History and physical, nutritional evaluation, psychological evaluation, weight loss attempts, social supports.                                          | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR716.003               | Bariatric Surgery                                                                 | Added prior to 9/1/2019   |                         |
| 43887               | REMOVE GASTRIC PORT OPEN      | History and physical, nutritional evaluation, psychological evaluation, weight loss attempts, social supports.                                          | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR716.003               | Bariatric Surgery                                                                 | Added prior to 9/1/2019   |                         |
| 43888               | CHANGE GASTRIC PORT OPEN      | history and physical, nutritional evaluation, psychological evaluation, weight loss attempts, social supports.                                          | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR716.003               | Bariatric Surgery                                                                 | Added prior to 9/1/2019   |                         |
| 43999               | STOMACH SURGERY PROCEDURE     | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | No Med Policy            | No medical policy                                                                 | Added prior to 9/1/2019   |                         |
| 44132               | ENTERECTOMY CADAVER DONOR     | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.014<br>SUR703.009 | Isolated Small Bowel Transplant<br>Small Bowel/Liver and Multivisceral Transplant | Added prior to 9/1/2019   |                         |
| 44133               | ENTERECTOMY LIVE DONOR        | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.014<br>SUR703.009 | Isolated Small Bowel Transplant<br>Small Bowel/Liver and Multivisceral Transplant | Added prior to 9/1/2019   |                         |
| 44135               | INTESTINE TRANSPLNT CADAVER   | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.014<br>SUR703.009 | Isolated Small Bowel Transplant<br>Small Bowel/Liver and Multivisceral Transplant | Added prior to 9/1/2019   |                         |
| 44136               | INTESTINE TRANSPLANT LIVE     | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Transplant                               | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.014<br>SUR703.009 | Isolated Small Bowel Transplant<br>Small Bowel/Liver and Multivisceral Transplant | Added prior to 9/1/2019   |                         |
| 44137               | REMOVE INTESTINAL ALLOGRAFT   | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.014<br>SUR703.009 | Isolated Small Bowel Transplant<br>Small Bowel/Liver and Multivisceral Transplant | Added prior to 9/1/2019   |                         |
| 44715               | PREPARE DONOR INTESTINE       | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Medicare NCD/LCD Guidelines , MCG, BCBS Medical Policy      | SUR703.014<br>SUR703.009 | Isolated Small Bowel Transplant<br>Small Bowel/Liver and Multivisceral Transplant | Added prior to 9/1/2019   |                         |
| 44720               | PREP DONOR INTESTINE/VENOUS   | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Medicare NCD/LCD Guidelines , MCG, BCBS Medical Policy      | SUR703.014<br>SUR703.009 | Isolated Small Bowel Transplant<br>Small Bowel/Liver and Multivisceral Transplant | Added prior to 9/1/2019   |                         |
| 44721               | PREP DONOR INTESTINE/ARTERY   | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Medicare NCD/LCD Guidelines , MCG, BCBS Medical Policy      | SUR703.014<br>SUR703.009 | Isolated Small Bowel Transplant<br>Small Bowel/Liver and Multivisceral Transplant | Added prior to 9/1/2019   |                         |
| 45126               | PELVIC EXENTERATION           | History and physical and procedure report.                                                                                                              | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | MCG GRG: SG-GS           | General Surgery or Procedure GRG                                                  | Added prior to 9/1/2019   |                         |
| 46760               | REPAIR OF ANAL SPHINCTER      | History and physical and procedure report.                                                                                                              | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR709.034               | Artificial Liver Assist Devices for the Treatment of Liver Failure                | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code | Medical Records Request Information Required                                                                                                            | Clinical Criteria Category               | Clinical Criteria Hierarchy                                 | Medical Policy Number    | Medical Policy Name                                                                                     | Effective and Change Date | Date Posted to Website* |
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| 47120               | PARTIAL REMOVAL OF LIVER      | History and physical and procedure report.                                                                                                              | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR709.034               | Artificial Liver Assist Devices for the Treatment of Liver Failure                                      | Added prior to 9/1/2019   |                         |
| 47122               | EXTENSIVE REMOVAL OF LIVER    | History and physical and procedure report.                                                                                                              | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR709.034               | Artificial Liver Assist Devices for the Treatment of Liver Failure                                      | Added prior to 9/1/2019   |                         |
| 47125               | PARTIAL REMOVAL OF LIVER      | History and physical and procedure report.                                                                                                              | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR709.034               | Artificial Liver Assist Devices for the Treatment of Liver Failure                                      | Added prior to 9/1/2019   |                         |
| 47130               | PARTIAL REMOVAL OF LIVER      | History and physical and procedure report.                                                                                                              | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR709.034               | Artificial Liver Assist Devices for the Treatment of Liver Failure                                      | Added prior to 9/1/2019   |                         |
| 47133               | REMOVAL OF DONOR LIVER        | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.008<br>SUR703.009 | Liver Transplant and Combined Liver-Kidney Transplant<br>Small Bowel/Liver and Multivisceral Transplant | Added prior to 9/1/2019   |                         |
| 47135               | TRANSPLANTATION OF LIVER      | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Transplant                               | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.008<br>SUR703.009 | Liver Transplant and Combined Liver-Kidney Transplant<br>Small Bowel/Liver and Multivisceral Transplant | Added prior to 9/1/2019   |                         |
| 47140               | PARTIAL REMOVAL DONOR LIVER   | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.008<br>SUR703.009 | Liver Transplant and Combined Liver-Kidney Transplant<br>Small Bowel/Liver and Multivisceral Transplant | Added prior to 9/1/2019   |                         |
| 47141               | PARTIAL REMOVAL DONOR LIVER   | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.008<br>SUR703.009 | Liver Transplant and Combined Liver-Kidney Transplant<br>Small Bowel/Liver and Multivisceral Transplant | Added prior to 9/1/2019   |                         |
| 47142               | PARTIAL REMOVAL DONOR LIVER   | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.008<br>SUR703.009 | Liver Transplant and Combined Liver-Kidney Transplant<br>Small Bowel/Liver and Multivisceral Transplant | Added prior to 9/1/2019   |                         |
| 47143               | PREP DONOR LIVER WHOLE        | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Medicare NCD/LCD Guidelines , MCG, BCBS Medical Policy      | SUR703.008<br>SUR703.009 | Liver Transplant and Combined Liver-Kidney Transplant<br>Small Bowel/Liver and Multivisceral Transplant | Added prior to 9/1/2019   |                         |
| 47144               | PREP DONOR LIVER 3-SEGMENT    | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Medicare NCD/LCD Guidelines , MCG, BCBS Medical Policy      | SUR703.008<br>SUR703.009 | Liver Transplant and Combined Liver-Kidney Transplant<br>Small Bowel/Liver and Multivisceral Transplant | Added prior to 9/1/2019   |                         |
| 47145               | PREP DONOR LIVER LOBE SPLIT   | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Medicare NCD/LCD Guidelines , MCG, BCBS Medical Policy      | SUR703.008<br>SUR703.009 | Liver Transplant and Combined Liver-Kidney Transplant<br>Small Bowel/Liver and Multivisceral Transplant | Added prior to 9/1/2019   |                         |
| 47146               | PREP DONOR LIVER/VENOUS       | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Medicare NCD/LCD Guidelines , MCG, BCBS Medical Policy      | SUR703.008<br>SUR703.009 | Liver Transplant and Combined Liver-Kidney Transplant<br>Small Bowel/Liver and Multivisceral Transplant | Added prior to 9/1/2019   |                         |
| 47147               | PARTIAL REMOVAL DONOR LIVER   | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Medicare NCD/LCD Guidelines , MCG, BCBS Medical Policy      | SUR703.008<br>SUR703.009 | Liver Transplant and Combined Liver-Kidney Transplant<br>Small Bowel/Liver and Multivisceral Transplant | Added prior to 9/1/2019   |                         |
| 47148               | PREP DONOR LIVER/ARTERIAL     | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Medicare NCD/LCD Guidelines , MCG, BCBS Medical Policy      | SUR703.008<br>SUR703.009 | Liver Transplant and Combined Liver-Kidney Transplant<br>Small Bowel/Liver and Multivisceral Transplant | Added prior to 9/1/2019   |                         |
| 47420               | INCISION OF BILE DUCT         | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.008<br>SUR703.009 | Liver Transplant and Combined Liver-Kidney Transplant<br>Small Bowel/Liver and Multivisceral Transplant | Added prior to 9/1/2019   |                         |
| 47425               | INCISION OF BILE DUCT         | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.008<br>SUR703.009 | Liver Transplant and Combined Liver-Kidney Transplant<br>Small Bowel/Liver and Multivisceral Transplant | Added prior to 9/1/2019   |                         |
| 48160               | PANCREAS REMOVAL/TRANSPLANT   | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Transplant                               | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.013               | Pancreas and Related Organ Tissue Transplantation                                                       | Added prior to 9/1/2019   |                         |
| 48550               | DONOR PANCREATECTOMY          | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.013               | Pancreas and Related Organ Tissue Transplantation                                                       | Added prior to 9/1/2019   |                         |
| 48551               | PREP DONOR PANCREAS           | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Medicare NCD/LCD Guidelines , MCG, BCBS Medical Policy      | SUR703.013               | Pancreas and Related Organ Tissue Transplantation                                                       | Added prior to 9/1/2019   |                         |
| 48552               | PREP DONOR PANCREAS/VENOUS    | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Medicare NCD/LCD Guidelines , MCG, BCBS Medical Policy      | SUR703.013               | Pancreas and Related Organ Tissue Transplantation                                                       | Added prior to 9/1/2019   |                         |
| 48554               | TRANSPL ALLOGRAFT PANCREAS    | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.013               | Pancreas and Related Organ Tissue Transplantation                                                       | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code | Medical Records Request Information Required                                                                                                            | Clinical Criteria Category               | Clinical Criteria Hierarchy                                 | Medical Policy Number                  | Medical Policy Name                                                                                                             | Effective and Change Date | Date Posted to Website* |
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| 48556               | REMOVAL ALLOGRAFT PANCREAS    | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.013                             | Pancreas and Related Organ Tissue Transplantation                                                                               | Added prior to 9/1/2019   |                         |
| 50300               | REMOVE CADAVER DONOR KIDNEY   | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.007<br>SUR703.008<br>SUR703.013 | Kidney Transplant<br>Liver Transplant and Combined Liver-Kidney Transplant<br>Pancreas and Related Organ Tissue Transplantation | Added prior to 9/1/2019   |                         |
| 50320               | REMOVE KIDNEY LIVING DONOR    | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.007<br>SUR703.008<br>SUR703.013 | Kidney Transplant<br>Liver Transplant and Combined Liver-Kidney Transplant<br>Pancreas and Related Organ Tissue Transplantation | Added prior to 9/1/2019   |                         |
| 50323               | PREP CADAVER RENAL ALLOGRAFT  | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.007<br>SUR703.008<br>SUR703.013 | Kidney Transplant<br>Liver Transplant and Combined Liver-Kidney Transplant<br>Pancreas and Related Organ Tissue Transplantation | Added prior to 9/1/2019   |                         |
| 50325               | PREP DONOR RENAL GRAFT        | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Medicare NCD/LCD Guidelines , MCG, BCBS Medical Policy      | SUR703.007<br>SUR703.008<br>SUR703.013 | Kidney Transplant<br>Liver Transplant and Combined Liver-Kidney Transplant<br>Pancreas and Related Organ Tissue Transplantation | Added prior to 9/1/2019   |                         |
| 50327               | PREP RENAL GRAFT/VEINOUS      | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Medicare NCD/LCD Guidelines , MCG, BCBS Medical Policy      | SUR703.007<br>SUR703.008<br>SUR703.013 | Kidney Transplant<br>Liver Transplant and Combined Liver-Kidney Transplant<br>Pancreas and Related Organ Tissue Transplantation | Added prior to 9/1/2019   |                         |
| 50328               | PREP RENAL GRAFT/ARTERIAL     | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.007<br>SUR703.008<br>SUR703.013 | Kidney Transplant<br>Liver Transplant and Combined Liver-Kidney Transplant<br>Pancreas and Related Organ Tissue Transplantation | Added prior to 9/1/2019   |                         |
| 50329               | PREP RENAL GRAFT/URETERAL     | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Medicare NCD/LCD Guidelines , MCG, BCBS Medical Policy      | SUR703.007<br>SUR703.008<br>SUR703.013 | Kidney Transplant<br>Liver Transplant and Combined Liver-Kidney Transplant<br>Pancreas and Related Organ Tissue Transplantation | Added prior to 9/1/2019   |                         |
| 50340               | REMOVAL OF KIDNEY             | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.007<br>SUR703.008<br>SUR703.013 | Kidney Transplant<br>Liver Transplant and Combined Liver-Kidney Transplant<br>Pancreas and Related Organ Tissue Transplantation | Added prior to 9/1/2019   |                         |
| 50360               | TRANSPLANTATION OF KIDNEY     | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Transplant                               | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.007<br>SUR703.008<br>SUR703.013 | Kidney Transplant<br>Liver Transplant and Combined Liver-Kidney Transplant<br>Pancreas and Related Organ Tissue Transplantation | Added prior to 9/1/2019   |                         |
| 50365               | TRANSPLANTATION OF KIDNEY     | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Transplant                               | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.007<br>SUR703.008<br>SUR703.013 | Kidney Transplant<br>Liver Transplant and Combined Liver-Kidney Transplant<br>Pancreas and Related Organ Tissue Transplantation | Added prior to 9/1/2019   |                         |
| 50370               | REMOVE TRANSPLANTED KIDNEY    | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Transplant                               | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.007<br>SUR703.008<br>SUR703.013 | Kidney Transplant<br>Liver Transplant and Combined Liver-Kidney Transplant<br>Pancreas and Related Organ Tissue Transplantation | Added prior to 9/1/2019   |                         |
| 50380               | REIMPLANTATION OF KIDNEY      | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.008<br>SUR703.013               | Liver Transplant and Combined Liver-Kidney Transplant<br>Pancreas and Related Organ Tissue Transplantation                      | Added prior to 9/1/2019   |                         |
| 50544               | LAPAROSCOPY PYELOPLASTY       | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.008<br>SUR703.013               | Liver Transplant and Combined Liver-Kidney Transplant<br>Pancreas and Related Organ Tissue Transplantation                      | Added prior to 9/1/2019   |                         |
| 50860               | TRANSPLANT URETER TO SKIN     | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.008<br>SUR703.013               | Liver Transplant and Combined Liver-Kidney Transplant<br>Pancreas and Related Organ Tissue Transplantation                      | Added prior to 9/1/2019   |                         |
| 51580               | REMOVE BLADDER/REVISE TRACT   | If transplant approval on record: Date of Transplant<br>If no Transplant approval: history and physical, transplant evaluation, and date of transplant. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.008<br>SUR703.013               | Liver Transplant and Combined Liver-Kidney Transplant<br>Pancreas and Related Organ Tissue Transplantation                      | Added prior to 9/1/2019   |                         |
| 51585               | REMOVAL OF BLADDER & NODES    | Submit history and physical, documentation of medical necessity, operative report.                                                                      | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.008<br>SUR703.013               | Liver Transplant and Combined Liver-Kidney Transplant<br>Pancreas and Related Organ Tissue Transplantation                      | Added prior to 9/1/2019   |                         |
| 51597               | REMOVAL OF PELVIC STRUCTURES  | Submit history and physical, documentation of medical necessity, operative report.                                                                      | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR703.008<br>SUR703.013               | Liver Transplant and Combined Liver-Kidney Transplant<br>Pancreas and Related Organ Tissue Transplantation                      | Added prior to 9/1/2019   |                         |
| 53020               | INCISION OF URETHRA           | Submit history and physical, documentation of medical necessity, operative report.                                                                      | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR717.001                             | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                 | Added 1/1/23              |                         |
| 53425               | RECONSTRUCT URETHRA STAGE 2   | Submit history and physical, documentation of medical necessity, operative report.                                                                      | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR717.001                             | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                 | Added 1/1/23              |                         |

| CPT and HCPCS Codes | Description of Procedure Code                                     | Medical Records Request Information Required                                                   | Clinical Criteria Category               | Clinical Criteria Hierarchy                                                                                                     | Medical Policy Number    | Medical Policy Name                                                                                                              | Effective and Change Date | Date Posted to Website* |
|---------------------|-------------------------------------------------------------------|------------------------------------------------------------------------------------------------|------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|--------------------------|----------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------|
| 53430               | RECONSTRUCTION OF URETHRA                                         | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR717.001               | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                  | Added prior to 9/1/2019   |                         |
| 54125               | REMOVAL OF PENIS                                                  | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR717.001               | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                  | Added prior to 9/1/2019   |                         |
| 54304               | REVISION OF PENIS                                                 | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR717.001               | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                  | Added prior to 9/1/2019   |                         |
| 54400               | INSERT SEMI-RIGID PROSTHESIS                                      | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR717.001<br>MED201.030 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Sexual Dysfunctions, Assessment and Treatment | Added prior to 9/1/2019   |                         |
| 54401               | INSERT SELF-CONTD PROSTHESIS                                      | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR717.001<br>MED201.030 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Sexual Dysfunctions, Assessment and Treatment | Added prior to 9/1/2019   |                         |
| 54405               | INSERT MULTI-COMP PENIS PROS                                      | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR717.001<br>MED201.030 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Sexual Dysfunctions, Assessment and Treatment | Added prior to 9/1/2019   |                         |
| 54406               | REMOVE MUTI-COMP PENIS PROS                                       | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR717.001<br>MED201.030 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Sexual Dysfunctions, Assessment and Treatment | Added prior to 9/1/2019   |                         |
| 54408               | REPAIR MULTI-COMP PENIS PROS                                      | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Medicare NCD/LCD Guidelines , MCG, BCBS Medical Policy                                                                          | SUR717.001<br>MED201.030 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Sexual Dysfunctions, Assessment and Treatment | Added prior to 9/1/2019   |                         |
| 54410               | REMOVE/REPLACE PENIS PROSTH                                       | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Medicare NCD/LCD Guidelines , MCG, BCBS Medical Policy                                                                          | SUR717.001<br>MED201.030 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Sexual Dysfunctions, Assessment and Treatment | Added prior to 9/1/2019   |                         |
| 54411               | REMOV/REPLC PENIS PROS COMP                                       | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Medicare NCD/LCD Guidelines , MCG, BCBS Medical Policy                                                                          | SUR717.001<br>MED201.030 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Sexual Dysfunctions, Assessment and Treatment | Added prior to 9/1/2019   |                         |
| 54415               | REMOVE SELF-CONTD PENIS PROS                                      | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Medicare NCD/LCD Guidelines , MCG, BCBS Medical Policy                                                                          | SUR717.001<br>MED201.030 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Sexual Dysfunctions, Assessment and Treatment | Added prior to 9/1/2019   |                         |
| 54416               | REMOV/REPL PENIS CONTAIN PROS                                     | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Medicare NCD/LCD Guidelines , MCG, BCBS Medical Policy                                                                          | SUR717.001<br>MED201.030 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Sexual Dysfunctions, Assessment and Treatment | Added prior to 9/1/2019   |                         |
| 54417               | REMOV/REPLC PENIS PROS COMPL                                      | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR717.001<br>MED201.030 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Sexual Dysfunctions, Assessment and Treatment | Added prior to 9/1/2019   |                         |
| 54520               | REMOVAL OF TESTIS                                                 | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR717.001               | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                  | Added prior to 9/1/2019   |                         |
| 54660               | REVISION OF TESTIS                                                | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR716.001<br>SUR717.001 | Cosmetic and Reconstructive Procedures<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services        | Added prior to 9/1/2019   |                         |
| 54690               | LAPAROSCOPY ORCHIECTOMY                                           | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR717.001               | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                  | Added 1/1/23              |                         |
| 55175               | REVISION OF SCROTUM                                               | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR717.001               | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                  | Added prior to 9/1/2019   |                         |
| 55180               | REVISION OF SCROTUM                                               | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR717.001               | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                  | Added prior to 9/1/2019   |                         |
| 55417               | REMOV/REPLC PENIS PROS COMPL                                      | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Medicare NCD/LCD Guidelines , MCG, BCBS Medical Policy                                                                          | SUR717.001<br>MED201.030 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Sexual Dysfunctions, Assessment and Treatment | Added prior to 9/1/2019   |                         |
| 55860               | INSERTION RADIOACTIVE SUBSTANCE PROSTATE                          | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 | Radiation Therapy                        | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                                                          | Change 8/1/2025           |                         |
| 55862               | INSERTAION OF RADIOACTIVE SUBSTANCE PROSTATE W/ LYMPH NODE BIOPSY | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 | Radiation Therapy                        | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                                                          | Change 8/1/2025           |                         |
| 55865               | INSERTION RADIOACTIVE SUBSTANCE PROSTATE WITH LYMPHADENECTOMY     | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 | Radiation Therapy                        | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                                                          | Change 8/1/2025           |                         |
| 55874               | TRANSPERINEAL PLACMENT OF BIODEGRADABLE MATERIAL PERI-PORSTATIC   | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 | Radiation Therapy                        | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                                                          | Change 8/1/2025           |                         |

| CPT and HCPCS Codes | Description of Procedure Code                                    | Medical Records Request Information Required                                       | Clinical Criteria Category               | Clinical Criteria Hierarchy                                 | Medical Policy Number              | Medical Policy Name                                                                                                                                              | Effective and Change Date | Date Posted to Website* |
|---------------------|------------------------------------------------------------------|------------------------------------------------------------------------------------|------------------------------------------|-------------------------------------------------------------|------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------|
| 55875               | PLACEMENT OF NEEDLES/CATHETERS INTO PROSTATE FOR RAD             | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiation Therapy                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                            | Carelon                                                                                                                                                          | Change 8/1/2025           |                         |
| 55899               | GENITAL SURGERY PROCEDURE                                        | Submit history and physical, documentation of medical necessity, operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR701.031, SUR710.019, SUR717.014 | Magnetic Resonance Image Guided Laser Interstitial Tumor Nerve Graft with Radical Prostatectomy High Intensity Focused Ultrasound (HIFU) for Treatment of Cancer | Added 1/1/23              |                         |
| 55920               | PLACEMENT OF NEEDLES/CATHETERS INTO PROSTATE FOR RAD APPLICATION | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiation Therapy                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                            | Carelon                                                                                                                                                          | Change 8/1/2025           |                         |
| 55970               | SEX TRANSFORMATION M TO F                                        | Submit history and physical, documentation of medical necessity, operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR717.001                         | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                                                  | Added prior to 9/1/2019   |                         |
| 55980               | SEX TRANSFORMATION F TO M                                        | Submit history and physical, documentation of medical necessity, operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR717.001                         | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                                                  | Added prior to 9/1/2019   |                         |
| 56620               | PARTIAL REMOVAL OF VULVA                                         | Submit history and physical, documentation of medical necessity, operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR717.001                         | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                                                  | Added 1/1/23              |                         |
| 56625               | COMPLETE REMOVAL OF VULVA                                        | Submit history and physical, documentation of medical necessity, operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR717.001                         | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                                                  | Added prior to 9/1/2019   |                         |
| 56800               | REPAIR OF VAGINA                                                 | Submit history and physical, documentation of medical necessity, operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR717.001                         | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                                                  | Added prior to 9/1/2019   |                         |
| 56805               | REPAIR CLITORIS                                                  | Submit history and physical, documentation of medical necessity, operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR717.001                         | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                                                  | Added prior to 9/1/2019   |                         |
| 56810               | REPAIR OF PERINEUM                                               | Submit history and physical, documentation of medical necessity, operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR717.001 MED201.030              | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Sexual Dysfunctions, Assessment and Treatment                                    | Added prior to 9/1/2019   |                         |
| 57106               | REMOVE VAGINA WALL PARTIAL                                       | Submit history and physical, documentation of medical necessity, operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR717.001                         | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                                                  | Added prior to 9/1/2019   |                         |
| 57107               | REMOVE VAGINA TISSUE PART                                        | Submit history and physical, documentation of medical necessity, operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR717.001                         | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                                                  | Added prior to 9/1/2019   |                         |
| 57110               | REMOVE VAGINA WALL COMPLETE                                      | Submit history and physical, documentation of medical necessity, operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR717.001                         | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                                                  | Added prior to 9/1/2019   |                         |
| 57111               | REMOVE VAGINA TISSUE COMPL                                       | Submit history and physical, documentation of medical necessity, operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR717.001                         | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                                                  | Added prior to 9/1/2019   |                         |
| 57155               | INSERTION OF UTERINE TANDEM OR VAG OVOIDS FOR BRACHYTHERAPY      | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiation Therapy                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                            | Carelon                                                                                                                                                          | Change 8/1/2025           |                         |
| 57156               | INSERTION OF VAGINAL RADIATION APPARATUS FOR BRACHYTHERAPY       | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiation Therapy                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                            | Carelon                                                                                                                                                          | Change 8/1/2025           |                         |
| 57288               | REPAIR BLADDER DEFECT                                            | Letter of medical necessity, including condition being treated.                    | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | No Med Policy                      | No medical policy                                                                                                                                                | Added prior to 9/1/2019   |                         |
| 57291               | CONSTRUCTION OF VAGINA                                           | Submit history and physical, documentation of medical necessity, operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR717.001                         | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                                                  | Added prior to 9/1/2019   |                         |
| 57292               | CONSTRUCT VAGINA WITH GRAFT                                      | Submit history and physical, documentation of medical necessity, operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR717.001                         | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                                                  | Added prior to 9/1/2019   |                         |
| 57295               | REVISE VAG GRAFT VIA VAGINA                                      | Submit history and physical, documentation of medical necessity, operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR717.001                         | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                                                  | Added prior to 9/1/2019   |                         |
| 57296               | REVISE VAG GRAFT OPEN ABD                                        | Submit history and physical, documentation of medical necessity, operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR717.001                         | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                                                  | Added prior to 9/1/2019   |                         |
| 57311               | REPAIR URETHROVAGINAL LESION                                     | Submit history and physical, documentation of medical necessity, operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR717.001                         | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                                                  | Added prior to 9/1/2019   |                         |
| 57335               | REPAIR VAGINA                                                    | Submit history and physical, documentation of medical necessity, operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR717.001 MED201.030              | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Sexual Dysfunctions, Assessment and Treatment                                    | Added prior to 9/1/2019   |                         |
| 57426               | REVISE PROSTH VAG GRAFT LAP                                      | Submit history and physical, documentation of medical necessity, operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR717.001                         | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                                                  | Added prior to 9/1/2019   |                         |
| 58150               | TOTAL HYSTERECTOMY                                               | Submit history and physical, documentation of medical necessity, operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR717.001                         | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                                                  | Added prior to 9/1/2019   |                         |
| 58180               | PARTIAL HYSTERECTOMY                                             | Submit history and physical, documentation of medical necessity, operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR717.001                         | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                                                  | Added prior to 9/1/2019   |                         |
| 58240               | REMOVAL OF PELVIS CONTENTS                                       | Submit history and physical, documentation of medical necessity, operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR717.001                         | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                                                  | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code                  | Medical Records Request Information Required                                                   | Clinical Criteria Category               | Clinical Criteria Hierarchy                                                                                                       | Medical Policy Number  | Medical Policy Name                                                                         | Effective and Change Date | Date Posted to Website* |
|---------------------|------------------------------------------------|------------------------------------------------------------------------------------------------|------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|------------------------|---------------------------------------------------------------------------------------------|---------------------------|-------------------------|
| 58260               | VAGINAL HYSTERECTOMY                           | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                       | SUR717.001             | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services             | Added prior to 9/1/2019   |                         |
| 58262               | VAG HYST INCLUDING T/O                         | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                       | SUR717.001             | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services             | Added prior to 9/1/2019   |                         |
| 58275               | HYSTERECTOMY/REVISE VAGINA                     | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                       | SUR717.001             | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services             | Added prior to 9/1/2019   |                         |
| 58280               | HYSTERECTOMY/REVISE VAGINA                     | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                       | SUR717.001             | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services             | Added prior to 9/1/2019   |                         |
| 58285               | EXTENSIVE HYSTERECTOMY                         | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                       | SUR717.001             | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services             | Added prior to 9/1/2019   |                         |
| 58290               | VAG HYST COMPLEX                               | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                       | SUR717.001             | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services             | Added prior to 9/1/2019   |                         |
| 58291               | VAG HYST INCL T/O COMPLEX                      | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                       | SUR717.001             | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services             | Added prior to 9/1/2019   |                         |
| 58346               | INSERTION OF HEYMAN CAPSULES FOR BRACHYTHERAPY | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 | Radiation Therapy                        | <a href="https://guidelines.carelonmedicaidbenefitsmanagement.com/">https://guidelines.carelonmedicaidbenefitsmanagement.com/</a> | Carelon                | Carelon                                                                                     | Change 8/1/2025           |                         |
| 58541               | LSH UTERUS 250 G OR LESS                       | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                       | SUR717.001             | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services             | Added prior to 9/1/2019   |                         |
| 58542               | LSH W/T/O UT 250 G OR LESS                     | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                       | SUR717.001             | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services             | Added prior to 9/1/2019   |                         |
| 58543               | LSH UTERUS ABOVE 250 G                         | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                       | SUR717.001             | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services             | Added prior to 9/1/2019   |                         |
| 58544               | LSH W/T/O UTERUS ABOVE 250 G                   | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                       | SUR717.001             | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services             | Added prior to 9/1/2019   |                         |
| 58550               | LAPARO-ASST VAG HYSTERECTOMY                   | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                       | SUR717.001             | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services             | Added prior to 9/1/2019   |                         |
| 58552               | LAPARO-VAG HYST INCL T/O                       | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                       | SUR717.001             | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services             | Added prior to 9/1/2019   |                         |
| 58553               | LAPARO-VAG HYST COMPLEX                        | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                       | SUR717.001             | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services             | Added prior to 9/1/2019   |                         |
| 58554               | LAPARO-VAG HYST W/T/O COMPL                    | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                       | SUR717.001             | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services             | Added prior to 9/1/2019   |                         |
| 58570               | TLH UTERUS 250 G OR LESS                       | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                       | SUR717.001             | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services             | Added prior to 9/1/2019   |                         |
| 58571               | TLH W/T/O 250 G OR LESS                        | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                       | SUR717.001             | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services             | Added prior to 9/1/2019   |                         |
| 58572               | TLH UTERUS OVER 250 G                          | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                       | SUR717.001             | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services             | Added prior to 9/1/2019   |                         |
| 58573               | TLH W/T/O UTERUS OVER 250 G                    | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                       | SUR717.001             | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services             | Added prior to 9/1/2019   |                         |
| 58670               | LAPAROSCOPY TUBAL CAUTERY                      | Letter of medical necessity, including condition being treated.                                | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                       | SUR701.014             | Endoscopic, Arthroscopic, Laparoscopic, Bronchoscopic and Thoracoscopic Surgery             | Added prior to 9/1/2019   |                         |
| 58672               | LAPAROSCOPY FIMBRIOPLASTY                      | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                       | SUR701.014             | Endoscopic, Arthroscopic, Laparoscopic, Bronchoscopic and Thoracoscopic Surgery             | Added prior to 9/1/2019   |                         |
| 58720               | REMOVAL OF OVARY/TUBE(S)                       | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                       | SUR717.001             | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services             | Added prior to 9/1/2019   |                         |
| 58760               | FIMBRIOPLASTY                                  | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Medicare NCD/LCD Guidelines , MCG, BCBS Medical Policy                                                                            | SUR701.014             | Endoscopic, Arthroscopic, Laparoscopic, Bronchoscopic and Thoracoscopic Surgery             | Added prior to 9/1/2019   |                         |
| 58940               | REMOVAL OF OVARY(S)                            | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                       | SUR717.001             | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services             | Added 1/1/23              |                         |
| 58999               | GENITAL SURGERY PROCEDURE                      | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                       | MED201.030, SUR717.016 | Sexual Dysfunctions, Assessment and Treatment Laser Treatment of Vulvovaginal Atrophy (VVA) | Added 1/1/23              |                         |
| 59300               | EPISIOTOMY OR VAGINAL REPAIR                   | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                       | SUR717.001             | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services             | Added 1/1/23              |                         |
| 60210               | PARTIAL THYROID EXCISION                       | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                       | SUR717.001             | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services             | Added 1/1/23              |                         |
| 60212               | PARTIAL THYROID EXCISION                       | Submit history and physical, documentation of medical necessity, operative report.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                       | SUR717.001             | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services             | Added 1/1/23              |                         |
| 60512               | AUTOTRANSPLANT PARATHYROID                     | Submit history and physical, documentation of medical necessity including operative report.    | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                       | SUR717.001             | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services             | Added prior to 9/1/2019   |                         |
| 61796               | SRS CRANIAL LESION, SIMPLE                     | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 | Radiation Therapy                        | <a href="https://guidelines.carelonmedicaidbenefitsmanagement.com/">https://guidelines.carelonmedicaidbenefitsmanagement.com/</a> | Carelon                | Carelon                                                                                     | Change 8/1/2025           |                         |

| CPT and HCPCS Codes | Description of Procedure Code   | Medical Records Request Information Required                                                          | Clinical Criteria Category               | Clinical Criteria Hierarchy                                 | Medical Policy Number    | Medical Policy Name                                                                                                                                                                                | Effective and Change Date | Date Posted to Website* |
|---------------------|---------------------------------|-------------------------------------------------------------------------------------------------------|------------------------------------------|-------------------------------------------------------------|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------|
| 61797               | SRS CRANIAL LESION, SIMPLE ADDL | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Radiation Therapy                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| 61798               | SRS CRANIAL LESION COMPLEX      | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Radiation Therapy                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| 61799               | SRS CRANIAL LESION COMPLEX ADDL | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Radiation Therapy                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| 61800               | APPLY SRS HEADFRAME ADD-ON      | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Radiation Therapy                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| 62115               | REDUCTION OF SKULL DEFECT       | Submit history and physical, documentation of medical necessity including operative report.           | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR717.001               | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                                                                                    | Added prior to 9/1/2019   |                         |
| 62120               | REPAIR SKULL CAVITY LESION      | Submit history and physical, documentation of medical necessity including operative report.           | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR717.001               | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services                                                                                                                    | Added prior to 9/1/2019   |                         |
| 62263               | EPIDURAL LYSIS MULT SESSIONS    | Submit history and physical, documentation of medical necessity including operative report.           | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR712.024               | Lysis of Epidural Adhesions                                                                                                                                                                        | 1/1/2020                  |                         |
| 62280               | TREAT SPINAL CORD LESION        | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| 62281               | TREAT SPINAL CORD LESION        | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| 62282               | TREAT SPINAL CANAL LESION       | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| 62287               | PERCUTANEOUS DISCECTOMY         | Submit history and physical, documentation of medical necessity, including functional impairment      | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR712.037<br>SUR712.004 | Decompression of the Intervertebral disc Using Laser Energy (Laser Discectomy) or Radiofrequency Coblation (Nucleoplasty) Automated Percutaneous Discectomy and Percutaneous Endoscopic Discectomy | 1/1/2020                  |                         |
| 62292               | NIX CHEMONUCLEOLYSIS LMBR       | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| 62320               | NIX INTERLAMINAR CRV/THRC       | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| 62321               | NIX INTERLAMINAR CRV/THRC       | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| 62322               | NIX INTERLAMINAR LMBR/SAC       | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| 62323               | NIX INTERLAMINAR LMBR/SAC       | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| 62324               | NIX INTERLAMINAR CRV/THRC       | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| 62325               | NIX INTERLAMINAR CRV/THRC       | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| 62326               | NIX INTERLAMINAR LMBR/SAC       | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| 62327               | NIX INTERLAMINAR LMBR/SAC       | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| 62350               | IMPLANT SPINAL CANAL CATH       | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR707.008               | Implantable Infusion Pump for Pain and Spasticity                                                                                                                                                  | 11/1/2019                 |                         |
| 62351               | IMPLANT SPINAL CANAL CATH       | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR707.008               | Implantable Infusion Pump for Pain and Spasticity                                                                                                                                                  | 11/1/2019                 |                         |
| 62360               | INSERT SPINE INFUSION DEVICE    | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR707.009               | Implantable Infusion Pump for Pain and Spasticity                                                                                                                                                  | 11/1/2019                 |                         |
| 62361               | IMPLANT SPINE INFUSION PUMP     | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR707.010               | Implantable Infusion Pump for Pain and Spasticity                                                                                                                                                  | 11/1/2019                 |                         |
| 62362               | IMPLANT SPINE INFUSION PUMP     | Pre-operative evaluation, history and physical including functional impairment, and operative report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR707.010               | Implantable Infusion Pump for Pain and Spasticity                                                                                                                                                  | Added prior to 9/1/2021   |                         |
| 63001               | REMOVE SPINE LAMINA 1/2 CRVL    | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| 63005               | REMOVE SPINE LAMINA 1/2 LMBR    | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| 63012               | REMOVE LAMINA/FACETS LUMBAR     | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| 63015               | REMOVE SPINE LAMINA >2 CRVCL    | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| 63017               | REMOVE SPINE LAMINA >2 LMBR     | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| 63020               | NECK SPINE DISK SURGERY         | Carelon-https://providerportal.com/ or 866-455-8415                                                   | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |

| CPT and HCPCS Codes | Description of Procedure Code | Medical Records Request Information Required        | Clinical Criteria Category | Clinical Criteria Hierarchy                              | Medical Policy Number | Medical Policy Name | Effective and Change Date | Date Posted to Website* |
|---------------------|-------------------------------|-----------------------------------------------------|----------------------------|----------------------------------------------------------|-----------------------|---------------------|---------------------------|-------------------------|
| 63030               | LOW BACK DISK SURGERY         | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 63035               | SPINAL DISK SURGERY ADD-ON    | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 63040               | LAMINOTOMY SINGLE CERVICAL    | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 63042               | LAMINOTOMY SINGLE LUMBAR      | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 63043               | LAMINOTOMY ADDL CERVICAL      | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 63044               | LAMINOTOMY ADDL LUMBAR        | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 63045               | REMOVE SPINE LAMINA 1 CRVL    | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 63047               | REMOVE SPINE LAMINA 1 LMBR    | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 63048               | REMOVE SPINAL LAMINA ADD-ON   | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 63050               | CERVICAL LAMINOPLSTY 2/> SEG  | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 63051               | C-LAMINOPLASTY W/GRAFT/PLATE  | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 63052               | Lam facetc/frmt arthrd lum 1  | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 63053               | Lam factc/frmt arthrd lum ea  | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 63056               | DECOMPRESS SPINAL CORD LMBR   | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 63057               | DECOMPRESS SPINE CORD ADD-ON  | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 63075               | NECK SPINE DISK SURGERY       | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 63076               | NECK SPINE DISK SURGERY       | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 63081               | REMOVE VERT BODY DCMPRN CRVL  | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 63082               | REMOVE VERTEBRAL BODY ADD-ON  | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 63620               | SRS SPINAL LESION             | Carelon-https://providerportal.com/ or 866-455-8415 | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 63621               | SRS SPINAL LESION ADDL        | Carelon-https://providerportal.com/ or 866-455-8415 | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 63650               | IMPLANT NEUROELECTRODES       | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 63655               | IMPLANT NEUROELECTRODES       | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 63685               | INSRT/REDO SPINE N GENERATOR  | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 64451               | NIX AA&STRD NRV NRVGT SI JT   | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 64479               | INJ FORAMEN EPIDURAL C/T      | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 64480               | INJ FORAMEN EPIDURAL ADD-ON   | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 64483               | INJ FORAMEN EPIDURAL L/S      | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 64484               | INJ FORAMEN EPIDURAL ADD-ON   | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 64490               | INJ PARAVERT F JNT C/T 1 LEV  | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 64491               | INJ PARAVERT F JNT C/T 2 LEV  | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 64492               | INJ PARAVERT F JNT C/T 3 LEV  | Carelon-https://providerportal.com/ or 866-455-8415 | Musculoskeletal            | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |

| CPT and HCPCS Codes | Description of Procedure Code             | Medical Records Request Information Required                                                                           | Clinical Criteria Category               | Clinical Criteria Hierarchy                                 | Medical Policy Number                                                                                                                                                             | Medical Policy Name                                                                                                                                                                                                                                                            | Effective and Change Date | Date Posted to Website* |
|---------------------|-------------------------------------------|------------------------------------------------------------------------------------------------------------------------|------------------------------------------|-------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------|
| 64493               | INJ PARAVERT F JNT L/S 1 LEV              | Carelon-https://providerportal.com/ or 866-455-8415                                                                    | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                                                                                                                                                                           | Carelon                                                                                                                                                                                                                                                                        | Change 8/1/2025           |                         |
| 64494               | INJ PARAVERT F JNT L/S 2 LEV              | Carelon-https://providerportal.com/ or 866-455-8415                                                                    | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                                                                                                                                                                           | Carelon                                                                                                                                                                                                                                                                        | Change 8/1/2025           |                         |
| 64495               | INJ PARAVERT F JNT L/S 3 LEV              | Carelon-https://providerportal.com/ or 866-455-8415                                                                    | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                                                                                                                                                                           | Carelon                                                                                                                                                                                                                                                                        | Change 8/1/2025           |                         |
| 64510               | N BLOCK STELLATE GANGLION                 | Carelon-https://providerportal.com/ or 866-455-8415                                                                    | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                                                                                                                                                                           | Carelon                                                                                                                                                                                                                                                                        | Change 8/1/2025           |                         |
| 64520               | N BLOCK LUMBAR/THORACIC                   | Carelon-https://providerportal.com/ or 866-455-8415                                                                    | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                                                                                                                                                                           | Carelon                                                                                                                                                                                                                                                                        | Change 8/1/2025           |                         |
| 64561               | IMPLANT NEUROELECTRODES                   | Submit History and Physical, documentation of medical necessity including operative report.                            | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR710.018                                                                                                                                                                        | Sacral Nerve Neuromodulation/Stimulation                                                                                                                                                                                                                                       | Added prior to 9/1/2019   |                         |
| 64625               | RF ABLTJ NRV NRVGTG SI JT                 | Carelon-https://providerportal.com/ or 866-455-8415                                                                    | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                                                                                                                                                                           | Carelon                                                                                                                                                                                                                                                                        | Change 8/1/2025           |                         |
| 64633               | DESTROY CERV/THOR FACET JNT               | Carelon-https://providerportal.com/ or 866-455-8415                                                                    | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                                                                                                                                                                           | Carelon                                                                                                                                                                                                                                                                        | Change 8/1/2025           |                         |
| 64634               | DESTROY C/TH FACET JNT ADDL               | Carelon-https://providerportal.com/ or 866-455-8415                                                                    | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                                                                                                                                                                           | Carelon                                                                                                                                                                                                                                                                        | Change 8/1/2025           |                         |
| 64635               | DESTROY LUMB/SAC FACET JNT                | Carelon-https://providerportal.com/ or 866-455-8415                                                                    | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                                                                                                                                                                           | Carelon                                                                                                                                                                                                                                                                        | Change 8/1/2025           |                         |
| 64636               | DESTROY L/S FACET JNT ADDL                | Carelon-https://providerportal.com/ or 866-455-8415                                                                    | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                                                                                                                                                                           | Carelon                                                                                                                                                                                                                                                                        | Change 8/1/2025           |                         |
| 64999               | NERVOUS SYSTEM SURGERY                    | Submit documentation to describe the services. Include history and physical with operative report or procedure report. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | RX501.019<br>SUR703.003<br>SUR702.017<br>SUR712.024<br>SUR701.031<br>MED205.037<br>SUR710.019<br>SUR712.033<br>MED205.032<br>MED205.035<br>MED205.036<br>MED205.039<br>MED201.020 | Botulinum Toxin<br>Brain Tissue Transplantation and Neurotransplantation<br>Facet Joint and Sacroiliac Joint Denervation<br>Lysis of Epidural Adhesions<br>Magnetic Resonance Image Guided Laser Interstitial Tumor Therapy (LITT)<br>Navigated Transcranial Magnetic Stimulat | Added prior to 9/1/2019   |                         |
| 65780               | OCULAR RECONST TRANSPLANT                 | Pre-operative evaluation, history and physical and operative report.                                                   | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR704.011                                                                                                                                                                        | Amniotic Membrane and Amniotic Fluid                                                                                                                                                                                                                                           | Added prior to 9/1/2019   |                         |
| 67218               | DESTRUCTION OF LOCALIZED LESION OF RETINA | Carelon-https://providerportal.com/ or 866-455-8415                                                                    | Radiation Therapy                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                                                                                                                                                                           | Carelon                                                                                                                                                                                                                                                                        | Change 8/1/2025           |                         |
| 67900               | REPAIR BROW DEFECT                        | Pre Operative Evaluation, History and Physical and Operative report                                                    | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR716.004<br>SUR712.031                                                                                                                                                          | Blepharoplasty, Blepharoptosis and Brow Repair<br>Surgical Deactivation of Headache Trigger Sites                                                                                                                                                                              | 1/1/2020                  |                         |
| 67901               | REPAIR EYELID DEFECT                      | Letter of medical necessity, including condition being treated.                                                        | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR716.004                                                                                                                                                                        | Blepharoplasty, Blepharoptosis and Brow Repair                                                                                                                                                                                                                                 | 1/1/2020                  |                         |
| 67902               | REPAIR EYELID DEFECT                      | Letter of medical necessity, including condition being treated.                                                        | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR716.004                                                                                                                                                                        | Blepharoplasty, Blepharoptosis and Brow Repair                                                                                                                                                                                                                                 | 1/1/2020                  |                         |
| 67903               | REPAIR EYELID DEFECT                      | Letter of medical necessity, including condition being treated.                                                        | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR716.004                                                                                                                                                                        | Blepharoplasty, Blepharoptosis and Brow Repair                                                                                                                                                                                                                                 | 1/1/2020                  |                         |
| 67904               | REPAIR EYELID DEFECT                      | Letter of medical necessity, including condition being treated.                                                        | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR716.004                                                                                                                                                                        | Blepharoplasty, Blepharoptosis and Brow Repair                                                                                                                                                                                                                                 | 1/1/2020                  |                         |
| 67906               | REPAIR EYELID DEFECT                      | Letter of medical necessity, including condition being treated.                                                        | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR716.004                                                                                                                                                                        | Blepharoplasty, Blepharoptosis and Brow Repair                                                                                                                                                                                                                                 | 1/1/2020                  |                         |
| 67908               | REPAIR EYELID DEFECT                      | Letter of medical necessity, including condition being treated.                                                        | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR716.004                                                                                                                                                                        | Blepharoplasty, Blepharoptosis and Brow Repair                                                                                                                                                                                                                                 | 1/1/2020                  |                         |
| 69300               | REVISE EXTERNAL EAR                       | Letter of medical necessity, including condition being treated.                                                        | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR716.001                                                                                                                                                                        | Cosmetic and Reconstructive Procedures                                                                                                                                                                                                                                         | 1/1/2020                  |                         |

| CPT and HCPCS Codes | Description of Procedure Code | Medical Records Request Information Required                                                          | Clinical Criteria Category               | Clinical Criteria Hierarchy                                                                                                     | Medical Policy Number | Medical Policy Name                                        | Effective and Change Date | Date Posted to Website* |
|---------------------|-------------------------------|-------------------------------------------------------------------------------------------------------|------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|-----------------------|------------------------------------------------------------|---------------------------|-------------------------|
| 69604               | MASTOID SURGERY REVISION      | Pre-operative evaluation, history and physical and operative report.                                  | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR716.001            | Cosmetic and Reconstructive Procedures                     | Added prior to 9/1/2019   |                         |
| 69714               | IMPLANT TEMPLE BONE W/STIMUL  | Pre-operative evaluation, history and physical and operative report.                                  | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR714.003            | Implantable Bone-Conduction and Bone-Anchored Hearing Aids | Added prior to 9/1/2019   |                         |
| 69715               | TEMPLE BNE IMPLNT W/STIMULAT  | Pre-operative evaluation, operative eport, previous use of hearing aids, level of hearing impairment. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR714.003            | Implantable Bone-Conduction and Bone-Anchored Hearing Aids | Added prior to 9/1/2019   |                         |
| 69717               | TEMPLE BONE IMPLANT REVISION  | Pre-operative evaluation, operative eport, previous use of hearing aids, level of hearing impairment. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR714.003            | Implantable Bone-Conduction and Bone-Anchored Hearing Aids | Added prior to 9/1/2019   |                         |
| 69718               | REVISE TEMPLE BONE IMPLANT    | Pre-operative evaluation, operative eport, previous use of hearing aids, level of hearing impairment. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR714.003            | Implantable Bone-Conduction and Bone-Anchored Hearing Aids | Added prior to 9/1/2019   |                         |
| 69930               | IMPLANT COCHLEAR DEVICE       | Pre-operative evaluation, operative eport, previous use of hearing aids, level of hearing impairment. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR714.004            | Cochlear Implant                                           | Added prior to 9/1/2019   |                         |
| 70336               | MAGNETIC IMAGE JAW JOINT      | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415        | Radiology                                | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                    | Change 8/1/2025           |                         |
| 70450               | CT HEAD/BRAIN W/O DYE         | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415        | Radiology                                | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                    | Change 8/1/2025           |                         |
| 70460               | CT HEAD/BRAIN W/DYE           | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415        | Radiology                                | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                    | Change 8/1/2025           |                         |
| 70470               | CT HEAD/BRAIN W/O & W/DYE     | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415        | Radiology                                | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                    | Change 8/1/2025           |                         |
| 70480               | CT ORBIT/EAR/FOSSA W/O DYE    | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415        | Radiology                                | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                    | Change 8/1/2025           |                         |
| 70481               | CT ORBIT/EAR/FOSSA W/DYE      | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415        | Radiology                                | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                    | Change 8/1/2025           |                         |
| 70482               | CT ORBIT/EAR/FOSSA W/O&W/DYE  | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415        | Radiology                                | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                    | Change 8/1/2025           |                         |
| 70486               | CT MAXILLOFACIAL W/O DYE      | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415        | Radiology                                | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                    | Change 8/1/2025           |                         |
| 70487               | CT MAXILLOFACIAL W/DYE        | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415        | Radiology                                | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                    | Change 8/1/2025           |                         |
| 70488               | CT MAXILLOFACIAL W/O & W/DYE  | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415        | Radiology                                | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                    | Change 8/1/2025           |                         |
| 70490               | CT SOFT TISSUE NECK W/O DYE   | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415        | Radiology                                | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                    | Change 8/1/2025           |                         |
| 70491               | CT SOFT TISSUE NECK W/DYE     | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415        | Radiology                                | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                    | Change 8/1/2025           |                         |
| 70492               | CT SFT TSUE NCK W/O & W/DYE   | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415        | Radiology                                | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                    | Change 8/1/2025           |                         |
| 70540               | MRI ORBIT/FACE/NECK W/O DYE   | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415        | Radiology                                | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                    | Change 8/1/2025           |                         |
| 70542               | MRI ORBIT/FACE/NECK W/DYE     | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415        | Radiology                                | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                    | Change 8/1/2025           |                         |
| 70543               | MRI ORBT/FAC/NCK W/O &W/DYE   | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415        | Radiology                                | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                    | Change 8/1/2025           |                         |
| 70544               | MR ANGIOGRAPHY HEAD W/O DYE   | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415        | Radiology                                | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                    | Change 8/1/2025           |                         |
| 70545               | MR ANGIOGRAPHY HEAD W/DYE     | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415        | Radiology                                | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                    | Change 8/1/2025           |                         |
| 70546               | MR ANGIOGRAPH HEAD W/O&W/DYE  | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415        | Radiology                                | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                    | Change 8/1/2025           |                         |
| 70547               | MR ANGIOGRAPHY NECK W/O DYE   | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415        | Radiology                                | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                    | Change 8/1/2025           |                         |
| 70548               | MR ANGIOGRAPHY NECK W/DYE     | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415        | Radiology                                | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                    | Change 8/1/2025           |                         |
| 70549               | MR ANGIOGRAPH NECK W/O&W/DYE  | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415        | Radiology                                | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                    | Change 8/1/2025           |                         |
| 70551               | MRI BRAIN STEM W/O DYE        | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415        | Radiology                                | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                    | Change 8/1/2025           |                         |
| 70552               | MRI BRAIN STEM W/DYE          | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415        | Radiology                                | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                    | Change 8/1/2025           |                         |
| 70553               | MRI BRAIN STEM W/O & W/DYE    | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415        | Radiology                                | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                    | Change 8/1/2025           |                         |

| CPT and HCPCS Codes | Description of Procedure Code | Medical Records Request Information Required        | Clinical Criteria Category | Clinical Criteria Hierarchy                              | Medical Policy Number | Medical Policy Name | Effective and Change Date | Date Posted to Website* |
|---------------------|-------------------------------|-----------------------------------------------------|----------------------------|----------------------------------------------------------|-----------------------|---------------------|---------------------------|-------------------------|
| 70554               | FMRI BRAIN BY TECH            | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 70555               | FMRI BRAIN BY PHYS/PSYCH      | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 71250               | CT THORAX W/O DYE             | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 71260               | CT THORAX W/DYE               | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 71270               | CT THORAX W/O & W/DYE         | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 71271               | CT THORAX, LUNG CANCER        | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 71275               | CT ANGIOGRAPHY CHEST          | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 71550               | MRI CHEST W/O DYE             | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 71551               | MRI CHEST W/DYE               | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 71552               | MRI CHEST W/O & W/DYE         | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 71555               | MRI ANGIO CHEST W OR W/O DYE  | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 72125               | CT NECK SPINE W/O DYE         | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 72126               | CT NECK SPINE W/DYE           | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 72127               | CT NECK SPINE W/O & W/DYE     | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 72128               | CT CHEST SPINE W/O DYE        | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 72129               | CT CHEST SPINE W/DYE          | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 72130               | CT CHEST SPINE W/O & W/DYE    | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 72131               | CT LUMBAR SPINE W/O DYE       | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 72132               | CT LUMBAR SPINE W/DYE         | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 72133               | CT LUMBAR SPINE W/O & W/DYE   | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 72141               | MRI NECK SPINE W/O DYE        | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 72142               | MRI NECK SPINE W/DYE          | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 72146               | MRI CHEST SPINE W/O DYE       | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 72147               | MRI CHEST SPINE W/DYE         | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 72148               | MRI LUMBAR SPINE W/O DYE      | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 72149               | MRI LUMBAR SPINE W/DYE        | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 72156               | MRI NECK SPINE W/O & W/DYE    | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 72157               | MRI CHEST SPINE W/O & W/DYE   | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 72158               | MRI LUMBAR SPINE W/O & W/DYE  | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 72159               | MR ANGIO SPINE W/O&W/DYE      | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 72191               | CT ANGIOGRAPH PELV W/O&W/DYE  | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 72192               | CT PELVIS W/O DYE             | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |

| CPT and HCPCS Codes | Description of Procedure Code | Medical Records Request Information Required        | Clinical Criteria Category | Clinical Criteria Hierarchy                              | Medical Policy Number | Medical Policy Name | Effective and Change Date | Date Posted to Website* |
|---------------------|-------------------------------|-----------------------------------------------------|----------------------------|----------------------------------------------------------|-----------------------|---------------------|---------------------------|-------------------------|
| 72193               | CT PELVIS W/DYE               | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 72194               | CT PELVIS W/O & W/DYE         | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 72195               | MRI PELVIS W/O DYE            | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 72196               | MRI PELVIS W/DYE              | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 72197               | MRI PELVIS W/O & W/DYE        | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 72198               | MR ANGIO PELVIS W/O & W/DYE   | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 73200               | CT UPPER EXTREMITY W/O DYE    | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 73201               | CT UPPER EXTREMITY W/DYE      | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 73202               | CT UPPER EXTREMITY W/O&W/DYE  | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 73206               | CT ANGIO UPR EXTRM W/O&W/DYE  | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 73218               | MRI UPPER EXTREMITY W/O DYE   | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 73219               | MRI UPPER EXTREMITY W/DYE     | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 73220               | MRI UPPER EXTREMITY W/O&W/DYE | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 73221               | MRI JOINT UPR EXTREM W/O DYE  | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 73222               | MRI JOINT UPR EXTREM W/DYE    | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 73223               | MRI JOINT UPR EXTR W/O&W/DYE  | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 73225               | MR ANGIO UPR EXTR W/O&W/DYE   | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 73700               | CT LOWER EXTREMITY W/O DYE    | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 73701               | CT LOWER EXTREMITY W/DYE      | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 73702               | CT LWR EXTREMITY W/O&W/DYE    | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 73706               | CT ANGIO LWR EXTR W/O&W/DYE   | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 73718               | MRI LOWER EXTREMITY W/O DYE   | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 73719               | MRI LOWER EXTREMITY W/DYE     | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 73720               | MRI LWR EXTREMITY W/O&W/DYE   | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 73721               | MRI JNT OF LWR EXTRE W/O DYE  | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 73722               | MRI JOINT OF LWR EXTR W/DYE   | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 73723               | MRI JOINT LWR EXTR W/O&W/DYE  | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 73725               | MR ANG LWR EXT W OR W/O DYE   | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 74150               | CT ABDOMEN W/O DYE            | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 74160               | CT ABDOMEN W/DYE              | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 74170               | CT ABDOMEN W/O & W/DYE        | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 74174               | CT ANGIO ABD&PELV W/O&W/DYE   | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |

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| 74175               | CT ANGIO ABDOM W/O & W/DYE                                    | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                                      | Change 8/1/2025           |                         |
| 74176               | CT ABD & PELVIS W/O CONTRAST                                  | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                                      | Change 8/1/2025           |                         |
| 74177               | CT ABD & PELV W/CONTRAST                                      | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                                      | Change 8/1/2025           |                         |
| 74178               | CT ABD & PELV 1/> REGNS                                       | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                                      | Change 8/1/2025           |                         |
| 74181               | MRI ABDOMEN W/O DYE                                           | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                                      | Change 8/1/2025           |                         |
| 74182               | MRI ABDOMEN W/DYE                                             | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                                      | Change 8/1/2025           |                         |
| 74183               | MRI ABDOMEN W/O & W/DYE                                       | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                                      | Change 8/1/2025           |                         |
| 74185               | MRI ANGIO ABDOM W ORW/O DYE                                   | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                                      | Change 8/1/2025           |                         |
| 74261               | CT COLONOGRAPHY DX                                            | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                                      | Change 8/1/2025           |                         |
| 74262               | CT COLONOGRAPHY DX W/DYE                                      | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                                      | Change 8/1/2025           |                         |
| 74263               | CT COLONOGRAPHY SCREENING                                     | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                                      | Change 8/1/2025           |                         |
| 74712               | MRI FETAL SNGL/1ST GESTATION                                  | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                                      | Change 8/1/2025           |                         |
| 74713               | MRI FETAL EA ADDL GESTATION                                   | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                                      | Change 8/1/2025           |                         |
| 75635               | CT ANGIO ABDOMINAL ARTERIES                                   | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                                      | Change 8/1/2025           |                         |
| 76377               | 3D RENDER W/INTRP POSTPROCES                                  | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                                      | Change 8/1/2025           |                         |
| 76380               | CAT SCAN FOLLOW-UP STUDY                                      | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                                      | Change 8/1/2025           |                         |
| 76390               | MR SPECTROSCOPY                                               | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                                      | Change 8/1/2025           |                         |
| 76391               | MR ELASTOGRAPHY                                               | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                                      | Change 8/1/2025           |                         |
| 76497               | CT PROCEDURE                                                  | Recent history and physical, plan of care, and documentation of medical necessity. | Radiology                  | Medicare NCD/LCD Guidelines , MCG, BCBS Medical Policy   | No Med Policy         | No medical policy                                                                            | Added prior to 9/1/2019   |                         |
| 76498               | MRI PROCEDURE                                                 | Recent history and physical, plan of care, and documentation of medical necessity. | Radiology                  | Medicare NCD/LCD Guidelines , MCG, BCBS Medical Policy   | RAD603.013            | Positional Magnetic Rsonance Imaging (MRI) and Standing or Portable Ultrasound for Scoliosis | Added prior to 9/1/2019   |                         |
| 76873               | ULTRASOUND TRANSRECTAL; PROSTATE VOL STUDY FOR BRACHYTHERAPY  | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                                      | Change 8/1/2025           |                         |
| 76965               | ULTRASOUND GUIDANCE FOR INTERSTITIAL RADIOELEMENT APPLICATION | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                                      | Change 8/1/2025           |                         |
| 77014               | CT GUIDANCE FOR PLACEMENT OF RADIATION THERAPY FIELDS         | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                                      | Change 8/1/2025           |                         |
| 77021               | MRI GUIDANCE NDL PLMT RS&I                                    | Recent history and physical, plan of care, and documentation of medical necessity. | Radiology                  | Medicare NCD/LCD Guidelines , MCG, BCBS Medical Policy   | MED201.039            | Tumor Treating Fields (TTF) Therapy                                                          | Added prior to 9/1/2019   |                         |
| 77022               | MRI GDN PARINCHYMA TISS ABLTJ                                 | Recent history and physical, plan of care, and documentation of medical necessity. | Radiology                  | Medicare NCD/LCD Guidelines , MCG, BCBS Medical Policy   | No Med Policy         | No medical policy                                                                            | Added prior to 9/1/2019   |                         |
| 77046               | MRI BREAST C- UNILATERAL                                      | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                                      | Change 8/1/2025           |                         |
| 77047               | MRI BREAST C- BILATERAL                                       | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                                      | Change 8/1/2025           |                         |
| 77048               | MRI BREAST C-+ W/CAD UNI                                      | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                                      | Change 8/1/2025           |                         |
| 77049               | MRI BREAST C-+ W/CAD BI                                       | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                                      | Change 8/1/2025           |                         |
| 77078               | CT BONE DENSITY AXIAL                                         | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon                                                                                      | Change 8/1/2025           |                         |

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| 77084               | MAGNETIC IMAGE BONE MARROW                                  | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 77295               | 3D RADIOTHERAPY PLAN, INCLUDING DOSE VOL HISTOGRAM          | Carelon-https://providerportal.com/ or 866-455-8415 | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 77301               | RADIOTHERAPY DOSE PLAN IMRT                                 | Carelon-https://providerportal.com/ or 866-455-8415 | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 77316               | BRACHYTX ISODOSE PLAN SIMPLE                                | Carelon-https://providerportal.com/ or 866-455-8415 | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 77317               | BRACHYTX ISODOSE PLAN INTERMED                              | Carelon-https://providerportal.com/ or 866-455-8415 | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 77318               | BRACHYTX ISODOSE PLAN COMPLEX                               | Carelon-https://providerportal.com/ or 866-455-8415 | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 77338               | DESIGN MLC DEVICE FOR IMRT                                  | Carelon-https://providerportal.com/ or 866-455-8415 | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 77370               | SPECIAL MEDICAL RADIATION PHYSICS CONS                      | Carelon-https://providerportal.com/ or 866-455-8415 | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 77371               | SRS MULTISOURCE                                             | Carelon-https://providerportal.com/ or 866-455-8415 | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 77372               | SRS LINEAR BASED                                            | Carelon-https://providerportal.com/ or 866-455-8415 | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 77373               | SBRT DELIVERY                                               | Carelon-https://providerportal.com/ or 866-455-8415 | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 77424               | INTRAOPERATIVE RADIATION TX DELIVERY XRAY SINGLE            | Carelon-https://providerportal.com/ or 866-455-8415 | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 77425               | INTRAOPERATIVE RADIATION TX DEL ELCTRONS SINGLE             | Carelon-https://providerportal.com/ or 866-455-8415 | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 77432               | SRT MANGMNT OF CRANIAL LESIONS                              | Carelon-https://providerportal.com/ or 866-455-8415 | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 77435               | SBRT TX MANGMNT PER TREATMENT COURSE TO 1 OR MORE LESIONS   | Carelon-https://providerportal.com/ or 866-455-8415 | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 77469               | INTRAOPERATIVE RADIATION TX MANGMNT                         | Carelon-https://providerportal.com/ or 866-455-8415 | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 77470               | SPECIAL RADIATION TX                                        | Carelon-https://providerportal.com/ or 866-455-8415 | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 77520               | PROTON TRMT SIMPLE W/O COMP                                 | Carelon-https://providerportal.com/ or 866-455-8415 | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 77522               | PROTON TRMT SIMPLE W/COMP                                   | Carelon-https://providerportal.com/ or 866-455-8415 | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 77523               | PROTON TRMT INTERMEDIATE                                    | Carelon-https://providerportal.com/ or 866-455-8415 | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 77525               | PROTON TREATMENT COMPLEX                                    | Carelon-https://providerportal.com/ or 866-455-8415 | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 77750               | Clinical Brachytherapy Radiation Treatment                  | Carelon-https://providerportal.com/ or 866-455-8415 | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Added 11/1/2025           | 9/1/2025                |
| 77761               | APPLY INTRCAV RADIATION SIMPLE                              | Carelon-https://providerportal.com/ or 866-455-8415 | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 77762               | APPLY INTRCAV RADIATION INTERMED                            | Carelon-https://providerportal.com/ or 866-455-8415 | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 77763               | APPLY INTRCAV RADIATION COMPLEX                             | Carelon-https://providerportal.com/ or 866-455-8415 | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 77767               | HDR SKIN SURFACE BRACHYTHERAPY LESION UP TO 2CM             | Carelon-https://providerportal.com/ or 866-455-8415 | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 77768               | HDR SKIN SURFACE BRACHYTHERAPY LESION OVER 2CM/MULT LESIONS | Carelon-https://providerportal.com/ or 866-455-8415 | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 77770               | HDR INTERSTITIAL/INTRACAV BRACHYTHERAPY 1 CHANNEL           | Carelon-https://providerportal.com/ or 866-455-8415 | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 77771               | HDR INTERSTITIAL/INTRACAV BRACHYTHERAPY MORE THAN 12 CHNLS  | Carelon-https://providerportal.com/ or 866-455-8415 | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |

| CPT and HCPCS Codes | Description of Procedure Code                      | Medical Records Request Information Required                                       | Clinical Criteria Category | Clinical Criteria Hierarchy                              | Medical Policy Number | Medical Policy Name | Effective and Change Date | Date Posted to Website* |
|---------------------|----------------------------------------------------|------------------------------------------------------------------------------------|----------------------------|----------------------------------------------------------|-----------------------|---------------------|---------------------------|-------------------------|
| 77772               | HDR INTERSTITIAL/INTRACAV BRACHYTHERAPY 2-12 CHNLS | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 77778               | INTERSTITIAL RAD SOURCE APPLICATION COMPLEX        | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 77790               | RADIATION HANDLING                                 | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78012               | THYROID UPTAKE MEASUREMENT                         | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78013               | THYROID IMAGING W/BLOOD FLOW                       | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78014               | THYROID IMAGING W/BLOOD FLOW                       | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78015               | THYROID MET IMAGING                                | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78016               | THYROID MET IMAGING/STUDIES                        | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78018               | THYROID MET IMAGING BODY                           | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78020               | THYROID MET UPTAKE                                 | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78070               | PARATHYROID PLANAR IMAGING                         | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78071               | PARATHYRD PLANAR W/WO SUBTRJ                       | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78072               | PARATHYRD PLANAR W/SPECT&CT                        | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78075               | ADRENAL CORTEX & MEDULLA IMG                       | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78102               | BONE MARROW IMAGING LTD                            | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78103               | BONE MARROW IMAGING MULT                           | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78104               | BONE MARROW IMAGING BODY                           | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78140               | Red cell sequestration                             | Recent history and physical, plan of care, and documentation of medical necessity. | Radiology                  | Medicare NCD/LCD Guidelines , MCG, BCBS Medical Policy   | No Med Policy         | No medical policy   | 5/18/2017                 |                         |
| 78185               | SPLEEN IMAGING                                     | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78195               | LYMPH SYSTEM IMAGING                               | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78201               | LIVER IMAGING                                      | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78202               | LIVER IMAGING WITH FLOW                            | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78215               | LIVER AND SPLEEN IMAGING                           | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78216               | LIVER & SPLEEN IMAGE/FLOW                          | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78226               | HEPATOBIILIARY SYSTEM IMAGING                      | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78227               | HEPATOBIL SYST IMAGE W/DRUG                        | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78230               | SALIVARY GLAND IMAGING                             | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78231               | SERIAL SALIVARY IMAGING                            | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78232               | SALIVARY GLAND FUNCTION EXAM                       | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78258               | ESOPHAGEAL MOTILITY STUDY                          | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78261               | GASTRIC MUCOSA IMAGING                             | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78262               | GASTROESOPHAGEAL REFLUX EXAM                       | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |

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| 78264               | GASTRIC EMPTYING IMAG STUDY   | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78265               | GASTRIC EMPTYING IMAG STUDY   | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78266               | GASTRIC EMPTYING IMAG STUDY   | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78278               | ACUTE GI BLOOD LOSS IMAGING   | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78290               | MECKELS DIVERT EXAM           | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78291               | LEVEEN/SHUNT PATENCY EXAM     | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78300               | BONE IMAGING LIMITED AREA     | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78305               | BONE IMAGING MULTIPLE AREAS   | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78306               | BONE IMAGING WHOLE BODY       | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78315               | BONE IMAGING 3 PHASE          | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78456               | ACUTE VENOUS THROMBUS IMAGE   | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78457               | VENOUS THROMBOSIS IMAGING     | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78458               | VEN THROMBOSIS IMAGES BILAT   | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78579               | LUNG VENTILATION IMAGING      | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78580               | LUNG PERFUSION IMAGING        | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78582               | LUNG VENTILAT&PERFUS IMAGING  | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78597               | LUNG PERFUSION DIFFERENTIAL   | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78598               | LUNG PERF&VENTILAT DIFERENTL  | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78600               | BRAIN IMAGE < 4 VIEWS         | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78601               | BRAIN IMAGE W/FLOW < 4 VIEWS  | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78605               | BRAIN IMAGE 4+ VIEWS          | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78606               | BRAIN IMAGE W/FLOW 4 + VIEWS  | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78608               | BRAIN IMAGING (PET)           | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78609               | BRAIN IMAGING (PET)           | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78610               | BRAIN FLOW IMAGING ONLY       | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78630               | CEREBROSPINAL FLUID SCAN      | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78635               | CSF VENTRICULOGRAPHY          | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78645               | CSF SHUNT EVALUATION          | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78650               | CSF LEAKAGE IMAGING           | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78660               | NUCLEAR EXAM OF TEAR FLOW     | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78700               | KIDNEY IMAGING MORPHOL        | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78701               | KIDNEY IMAGING WITH FLOW      | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |

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|---------------------|-----------------------------------------|-----------------------------------------------------|----------------------------|----------------------------------------------------------|-----------------------|---------------------|---------------------------|-------------------------|
| 78707               | K FLOW/FUNCT IMAGE W/O DRUG             | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78708               | K FLOW/FUNCT IMAGE W/DRUG               | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78709               | K FLOW/FUNCT IMAGE MULTIPLE             | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78725               | KIDNEY FUNCTION STUDY                   | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78730               | URINARY BLADDER RETENTION               | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78740               | URETERAL REFLUX STUDY                   | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78761               | TESTICULAR IMAGING W/FLOW               | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78800               | TUMOR IMAGING LIMITED AREA              | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78801               | TUMOR IMAGING MULT AREAS                | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78802               | TUMOR IMAGING WHOLE BODY                | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78803               | TUMOR IMAGING (3D)                      | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78804               | TUMOR IMAGING WHOLE BODY                | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78812               | PET IMAGE SKULL-THIGH                   | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78813               | PET IMAGE FULL BODY                     | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78814               | PET IMAGE W/CT LMED                     | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78815               | PET IMAGE W/CT SKULL-THIGH              | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78816               | PET IMAGE W/CT FULL BODY                | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78830               | RP LOCLZJ TUM SPECT W/CT 1              | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78831               | RP LOCLZJ TUM SPECT 2 AREAS             | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 78832               | RP LOCLZJ TUM SPECT W/CT 2              | Carelon-https://providerportal.com/ or 866-455-8415 | Radiology                  | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 79101               | NUCLEAR RX IV ADMIN                     | Carelon-https://providerportal.com/ or 866-455-8415 | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 79403               | HEMATOPOIETIC NUCLEAR TX                | Carelon-https://providerportal.com/ or 866-455-8415 | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81162               | BRCA1&2 GEN FULL SEQ DUP/DEL            | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81163               | BRCA1&2 GEN FULL SEQ DUP/DEL            | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81164               | BRCA1&2 GEN FULL SEQ DUP/DEL            | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81165               | BRCA1&2 GEN FULL SEQ DUP/DEL            | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81166               | BRCA1&2 GEN FULL SEQ DUP/DEL            | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81167               | BRCA1&2 GEN FULL SEQ DUP/DEL            | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81170               | ABL1 gene analysis                      | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Added 11/1/2025           | 9/1/2025                |
| 81171               | AFF2 gene analysis for abnormal alleles | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Added 11/1/2025           | 9/1/2025                |
| 81172               | AFF2 Gene Analysis                      | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Added 11/1/2025           | 9/1/2025                |
| 81173               | AR GENE FULL GENE SEQUENCE              | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |

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|---------------------|-------------------------------|-------------------------------------------------------------------------|----------------------------|-------------------------------------------------------------|-----------------------|---------------------|---------------------------|-------------------------|
| 81174               | AR GENE KNOWN FAMIL VARIANT   | Carelon-https://providerportal.com/ or 866-455-8415                     | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81189               | CSTB GENE FULL GENE SEQUENCE  | Carelon-https://providerportal.com/ or 866-455-8415                     | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81190               | CSTB GENE KNOWN FAMIL VRNT    | Carelon-https://providerportal.com/ or 866-455-8415                     | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81195               | OGM-Dx HemeOne                | Recent history & physical, plan of care and letter of medical necessity | Lab                        | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | No Med Policy         | No medical policy   | 4/1/2025                  |                         |
| 81201               | APC GENE FULL SEQUENCE        | Carelon-https://providerportal.com/ or 866-455-8415                     | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81202               | APC GENE KNOWN FAM VARIANTS   | Carelon-https://providerportal.com/ or 866-455-8415                     | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81203               | APC GENE DUP/DELET VARIANTS   | Carelon-https://providerportal.com/ or 866-455-8415                     | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81212               | BRCA1&2 185&538&6174 VRNT     | Carelon-https://providerportal.com/ or 866-455-8415                     | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81215               | BRCA1 GENE KNOWN FAMIL VRNT   | Carelon-https://providerportal.com/ or 866-455-8415                     | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81216               | BRCA2 GENE FULL SEQ ALYS      | Carelon-https://providerportal.com/ or 866-455-8415                     | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81217               | BRCA2 GENE KNOWN FAMIL VRNT   | Carelon-https://providerportal.com/ or 866-455-8415                     | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81221               | CFTR GENE KNOWN FAM VARIANTS  | Carelon-https://providerportal.com/ or 866-455-8415                     | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81222               | CFTR GENE DUP/DELET VARIANTS  | Carelon-https://providerportal.com/ or 866-455-8415                     | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81223               | CFTR GENE FULL SEQUENCE       | Carelon-https://providerportal.com/ or 866-455-8415                     | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81225               | CYP2C19 GENE COM VARIANTS     | Carelon-https://providerportal.com/ or 866-455-8415                     | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81226               | CYP2D6 GENE COM VARIANTS      | Carelon-https://providerportal.com/ or 866-455-8415                     | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81227               | CYP2C9 GENE COM VARIANTS      | Carelon-https://providerportal.com/ or 866-455-8415                     | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81228               | CYTOGEN MICRARRAY COPY NMBR   | Carelon-https://providerportal.com/ or 866-455-8415                     | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81229               | CYTOGEN M ARRAY COPY NO&SNP   | Carelon-https://providerportal.com/ or 866-455-8415                     | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81230               | CYP3A4 GENE COMMON VARIANTS   | Carelon-https://providerportal.com/ or 866-455-8415                     | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81231               | CYP3A5 GENE COMMON VARIANTS   | Carelon-https://providerportal.com/ or 866-455-8415                     | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81232               | DPYD GENE COMMON VARIANTS     | Carelon-https://providerportal.com/ or 866-455-8415                     | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81238               | F9 FULL GENE SEQUENCE         | Carelon-https://providerportal.com/ or 866-455-8415                     | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81248               | G6PD KNOWN FAMILIAL VARIANT   | Carelon-https://providerportal.com/ or 866-455-8415                     | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81249               | G6PD FULL GENE SEQUENCE       | Carelon-https://providerportal.com/ or 866-455-8415                     | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81252               | GJB2 GENE FULL SEQUENCE       | Carelon-https://providerportal.com/ or 866-455-8415                     | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81253               | GJB2 GENE KNOWN FAM VARIANTS  | Carelon-https://providerportal.com/ or 866-455-8415                     | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81257               | HBA1/HBA2 GENE                | Carelon-https://providerportal.com/ or 866-455-8415                     | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81258               | HBA1/HBA2 GENE FAM VRNT       | Carelon-https://providerportal.com/ or 866-455-8415                     | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81259               | HBA1/HBA2 FULL GENE SEQUENCE  | Carelon-https://providerportal.com/ or 866-455-8415                     | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81269               | HBA1/HBA2 GENE DUP/DEL VRNTS  | Carelon-https://providerportal.com/ or 866-455-8415                     | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |

| CPT and HCPCS Codes | Description of Procedure Code                           | Medical Records Request Information Required        | Clinical Criteria Category | Clinical Criteria Hierarchy                              | Medical Policy Number | Medical Policy Name | Effective and Change Date | Date Posted to Website* |
|---------------------|---------------------------------------------------------|-----------------------------------------------------|----------------------------|----------------------------------------------------------|-----------------------|---------------------|---------------------------|-------------------------|
| 81278               | Short description not available at time of distribution | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81279               | Short description not available at time of distribution | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81283               | IFNL3 GENE                                              | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81286               | FXN GENE FULL GENE SEQUENCE                             | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81289               | FXN GENE KNOWN FAMIL VARIANT                            | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81291               | MTHFR GENE                                              | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81292               | MLH1 GENE FULL SEQ                                      | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81293               | MLH1 GENE KNOWN VARIANTS                                | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81294               | MLH1 GENE DUP/DELETE VARIANT                            | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81295               | MSH2 GENE FULL SEQ                                      | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81296               | MSH2 GENE KNOWN VARIANTS                                | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81297               | MSH2 GENE DUP/DELETE VARIANT                            | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81298               | MSH6 GENE FULL SEQ                                      | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81299               | MSH6 GENE KNOWN VARIANTS                                | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81300               | MSH6 GENE DUP/DELETE VARIANT                            | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81302               | MECP2 GENE FULL SEQ                                     | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81303               | MECP2 GENE KNOWN VARIANT                                | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81304               | MECP2 GENE DUP/DELET VARIANT                            | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81306               | NUDT15 GENE COMMON VARIANTS                             | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81307               | PALB2 GENE FULL GENE SEQ                                | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81308               | PALB2 GENE KNOWN FAMIL VRNT                             | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81313               | PCA3/KLK3 ANTIGEN                                       | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81317               | PMS2 GENE FULL SEQ ANALYSIS                             | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81318               | PMS2 KNOWN FAMILIAL VARIANTS                            | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81319               | PMS2 GENE DUP/DELET VARIANTS                            | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81321               | PTEN GENE FULL SEQUENCE                                 | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81322               | PTEN GENE KNOWN FAM VARIANT                             | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81323               | PTEN GENE DUP/DELET VARIANT                             | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81325               | PMP22 GENE FULL SEQUENCE                                | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81326               | PMP22 GENE KNOWN FAM VARIANT                            | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81327               | SEPT9 GEN PRMTR MTHYLTN ALYS                            | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |

| CPT and HCPCS Codes | Description of Procedure Code | Medical Records Request Information Required        | Clinical Criteria Category | Clinical Criteria Hierarchy                              | Medical Policy Number | Medical Policy Name | Effective and Change Date | Date Posted to Website* |
|---------------------|-------------------------------|-----------------------------------------------------|----------------------------|----------------------------------------------------------|-----------------------|---------------------|---------------------------|-------------------------|
| 81328               | SLCO1B1 GENE COM VARIANTS     | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81335               | TPMT GENE COM VARIANTS        | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81336               | SMN1 GENE FULL GENE SEQUENCE  | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81337               | SMN1 GEN NOWN FAMIL SEQ VRNT  | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81346               | TYMS GENE COM VARIANTS        | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81349               | Cytog alys chrml abnr lw-ps   | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81350               | UGT1A1 GENE                   | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81351               | TP53 gene full gene sequence  | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81353               | TP53 gene known famil vrnt    | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81355               | VKORC1 GENE                   | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81361               | HBB GENE COM VARIANTS         | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81362               | HBB GENE KNOWN FAM VARIANT    | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81363               | HBB GENE DUP/DEL VARIANTS     | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81364               | HBB FULL GENE SEQUENCE        | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81400               | MOPATH PROCEDURE LEVEL 1      | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81401               | MOPATH PROCEDURE LEVEL 2      | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81402               | MOPATH PROCEDURE LEVEL 3      | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81403               | MOPATH PROCEDURE LEVEL 4      | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81404               | MOPATH PROCEDURE LEVEL 5      | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81405               | MOPATH PROCEDURE LEVEL 6      | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81406               | MOPATH PROCEDURE LEVEL 7      | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81407               | MOPATH PROCEDURE LEVEL 8      | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81408               | MOPATH PROCEDURE LEVEL 9      | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81410               | AORTIC DYSFUNCTION/DILATION   | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81411               | AORTIC DYSFUNCTION/DILATION   | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81412               | ASHKENAZI JEWISH ASSOC DIS    | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81415               | EXOME SEQUENCE ANALYSIS       | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81416               | EXOME SEQUENCE ANALYSIS       | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81417               | EXOME RE-EVALUATION           | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81419               | Epilepsy gen seq alys panel   | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81422               | FETAL CHROMOML MICRODELTY     | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81425               | GENOME SEQUENCE ANALYSIS      | Carelon-https://providerportal.com/ or 866-455-8415 | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/ | Carelon               | Carelon             | Change 8/1/2025           |                         |

| CPT and HCPCS Codes | Description of Procedure Code | Medical Records Request Information Required                                       | Clinical Criteria Category | Clinical Criteria Hierarchy                                 | Medical Policy Number | Medical Policy Name | Effective and Change Date | Date Posted to Website* |
|---------------------|-------------------------------|------------------------------------------------------------------------------------|----------------------------|-------------------------------------------------------------|-----------------------|---------------------|---------------------------|-------------------------|
| 81426               | GENOME SEQUENCE ANALYSIS      | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81427               | GENOME RE-EVALUATION          | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81430               | HEARING LOSS SEQUENCE ANALYS  | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81432               | HRDTRY BRST CA-RLATD DSORDRS  | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81433               | HRDTRY BRST CA-RLATD DSORDRS  | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81435               | HEREDITARY COLON CA DSORDRS   | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81436               | HEREDITARY COLON CA DSORDRS   | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81437               | HEREDTRY NURONDCRN TUM DSRDR  | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81438               | HEREDTRY NURONDCRN TUM DSRDR  | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81440               | MITOCHONDRIAL GENE            | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81441               | Ibmfs seq alys pnl 30 genes   | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81443               | TARGETED GENOMIC SEQ ANALYS   | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81445               | TARGETED GENOMIC SEQ ANALYS   | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81448               | HRDTRY PERPH NEURPHY PANEL    | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81449               | Tgsap so neo 5-50 rna alys    | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81450               | TARGETED GENOMIC SEQ ANALYS   | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81451               | Tgsap hl neo 5-50 rna alys    | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81455               | TARGETED GENOMIC SEQ ANALYS   | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81456               | Tgsap so/hl 51/< rna alys     | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81460               | WHOLE MITOCHONDRIAL GENOME    | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81465               | WHOLE MITOCHONDRIAL GENOME    | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81470               | X-LINKED INTELLECTUAL DBLT    | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81471               | X-LINKED INTELLECTUAL DBLT    | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81479               | UNLISTED MOLECULAR PATHOLOGY  | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81490               | AUTOIMMUNE RHEUMATOID ARTHR   | Recent history and physical, plan of care, and documentation of medical necessity. | Lab                        | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | No Med Policy         | No medical policy   | Added prior to 9/1/2019   |                         |
| 81500               | ONCO (OVAR) TWO PROTEINS      | Recent history and physical, plan of care, and documentation of medical necessity. | Lab                        | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | No Med Policy         | No medical policy   | Added prior to 9/1/2019   |                         |
| 81503               | ONCO (OVAR) FIVE PROTEINS     | Recent history and physical, plan of care, and documentation of medical necessity. | Lab                        | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | No Med Policy         | No medical policy   | Added prior to 9/1/2019   |                         |
| 81518               | ONCOLOGY BREAST MRNA          | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81519               | ONCOLOGY BREAST MRNA          | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81520               | ONC BREAST MRNA 58 GENES      | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81521               | ONC BREAST MRNA 70 GENES      | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |
| 81522               | ONC BREAST MRNA 12 GENES      | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                        | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon               | Carelon             | Change 8/1/2025           |                         |

| CPT and HCPCS Codes | Description of Procedure Code                                                                                       | Medical Records Request Information Required                                                                                                  | Clinical Criteria Category               | Clinical Criteria Hierarchy                                                        | Medical Policy Number                  | Medical Policy Name                                                                                                                          | Effective and Change Date | Date Posted to Website* |
|---------------------|---------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|------------------------------------------------------------------------------------|----------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------|
| 81523               | Short description not available at time of distribution                                                             | Carelon-https://providerportal.com/ or 866-455-8415                                                                                           | Lab                                      | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon                                | Carelon                                                                                                                                      | Change 8/1/2025           |                         |
| 81529               | Short description not available at time of distribution                                                             | Carelon-https://providerportal.com/ or 866-455-8415                                                                                           | Lab                                      | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon                                | Carelon                                                                                                                                      | Change 8/1/2025           |                         |
| 81535               | ONCOLOGY GYNECOLOGIC                                                                                                | Recent history and physical, plan of care, and documentation of medical necessity.                                                            | Lab                                      | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                        | SUR701.029                             | Hyperthermic Intraperitoneal Chemotherapy for Select Intra-Abdominal and Pelvic Malignancies                                                 | Added prior to 9/1/2019   |                         |
| 81536               | ONCOLOGY GYNECOLOGIC                                                                                                | Recent history and physical, plan of care, and documentation of medical necessity.                                                            | Lab                                      | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                        | No Med Policy                          | No medical policy                                                                                                                            | Added prior to 9/1/2019   |                         |
| 81538               | ONCOLOGY LUNG                                                                                                       | Recent history and physical, plan of care, and documentation of medical necessity.                                                            | Lab                                      | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                        | No Med Policy                          | No medical policy                                                                                                                            | Added prior to 9/1/2019   |                         |
| 81539               | ONCOLOGY PROSTATE PROB SCORE                                                                                        | Recent history and physical, plan of care, and documentation of medical necessity.                                                            | Lab                                      | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                        | No Med Policy                          | No medical policy                                                                                                                            | Added prior to 9/1/2019   |                         |
| 81541               | ONC PROSTATE MRNA 46 GENES                                                                                          | Carelon-https://providerportal.com/ or 866-455-8415                                                                                           | Lab                                      | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon                                | Carelon                                                                                                                                      | Change 8/1/2025           |                         |
| 81542               | ONC PROSTATE MRNA 22 CNT GEN                                                                                        | Carelon-https://providerportal.com/ or 866-455-8415                                                                                           | Lab                                      | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon                                | Carelon                                                                                                                                      | Change 8/1/2025           |                         |
| 81546               | ONC THYR MRNA 10,196 GENES FINE NDL ASPIRATE ALG                                                                    | Carelon-https://providerportal.com/ or 866-455-8415                                                                                           | Lab                                      | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon                                | Carelon                                                                                                                                      | Change 8/1/2025           |                         |
| 81554               | PULM DS IPF MRNA 190 GENE TRANSBRONCHIAL BX ALG                                                                     | Carelon-https://providerportal.com/ or 866-455-8415                                                                                           | Lab                                      | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon                                | Carelon                                                                                                                                      | Change 8/1/2025           |                         |
| 81558               | Short description not available at time of distribution                                                             | Recent history and physical, plan of care, and documentation of medical necessity.                                                            | Lab                                      | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                        | No Med Policy                          | No medical policy                                                                                                                            | 1/1/2025                  |                         |
| 81599               | UNLISTED MAAA                                                                                                       | Carelon-https://providerportal.com/ or 866-455-8415                                                                                           | Lab                                      | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon                                | Carelon                                                                                                                                      | Change 8/1/2025           |                         |
| 89250               | CULTR OOCYTE/EMBRYO <4 DAYS                                                                                         | Submit documentation to describe the test, records from related office visit, history and physical.                                           | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                        | OB402.023                              | Services for Infertility and Recurrent Fetal Loss                                                                                            | Added prior to 9/1/2019   |                         |
| 89290               | BIOPSY OOCYTE POLAR BODY                                                                                            | Submit documentation to describe the test, records from related office visit, history and physical.                                           | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                        | OB402.023                              | Services for Infertility and Recurrent Fetal Loss                                                                                            | Added prior to 9/1/2019   |                         |
| 89291               | BIOPSY OOCYTE POLAR BODY                                                                                            | Submit documentation to describe the test, records from related office visit, history and physical.                                           | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                        | OB402.023                              | Services for Infertility and Recurrent Fetal Loss                                                                                            | Added prior to 9/1/2019   |                         |
| 90281               | HUMAN IG IM                                                                                                         | Recent history and physical, plan of care, and documentation of medical necessity.                                                            | Medical Drug                             | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines | PSY301.014                             | <a href="#">Autism Spectrum Disorders (ASD)</a>                                                                                              | Change 11/1/2025          | 9/1/2025                |
| 90283               | HUMAN IG IV                                                                                                         | SRU                                                                                                                                           | Specialty Pharmacy                       | Illinois Medicaid Provider Manual, BCBS Medical Policy                             | RX504.003                              | Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])                                                        | Added prior to 9/1/2019   |                         |
| 90284               | HUMAN IG SC                                                                                                         | SRU                                                                                                                                           | Specialty Pharmacy                       | Illinois Medicaid Provider Manual, BCBS Medical Policy                             | RX504.003                              | Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])                                                        | Added prior to 9/1/2019   |                         |
| 90378               | RSV MAB IM 50MG                                                                                                     | SRU                                                                                                                                           | Specialty Pharmacy                       | Illinois Medicaid Provider Manual, BCBS Medical Policy                             | RX504.009                              | Respiratory Syncytial Virus (RSV) Immunoprophylaxis                                                                                          | Added prior to 9/1/2019   |                         |
| 90399               | IMMUNE GLOBULIN                                                                                                     | History and physical, chart notes from ordering physician, treatment plan.                                                                    | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                        | RX504.003                              | Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])                                                        | Added prior to 9/1/2019   |                         |
| 90863               | PHARMACOLOGIC MGMT W/PSYTX                                                                                          | History and physical, chart notes from ordering physician, treatment plan.                                                                    | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                        | PSY301.014<br>SUR717.001<br>PSY301.000 | Autism Spectrum Disorders (ASD)<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Mental Health Services | Added prior to 9/1/2019   |                         |
| 90935               | Hemodialysis procedure with single physician evaluation                                                             | *Prior Auth only required if greater than 3x per week. History and physical, chart notes from ordering physician, treatment plan and results. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                        | THE802.002                             | Daily Hemodialysis and Hemodialysis in the Home Setting                                                                                      | Prior to 9/1/2019         |                         |
| 90937               | Hemodialysis procedure requiring repeated evaluations with or without substantial revision of dialysis prescription | *Prior Auth only required if greater than 3x per week. History and physical, chart notes from ordering physician, treatment plan and results. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                        | THE802.002                             | Daily Hemodialysis and Hemodialysis in the Home Setting                                                                                      | Prior to 9/1/2019         |                         |
| 90999               | DIALYSIS PROCEDURE                                                                                                  | History and physical, chart notes from ordering physician, treatment plan and results.                                                        | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                        | THE802.002                             | Daily Hemodialysis and Hemodialysis in the Home Setting                                                                                      | Added prior to 9/1/2019   |                         |
| 92507               | SPEECH/HEARING THERAPY                                                                                              | Carelon-https://providerportal.com/ or 866-455-8415                                                                                           | Rehabilitation (PT/OT/ST)                | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon                                | Carelon                                                                                                                                      | Change 8/1/2025           |                         |
| 92508               | SPEECH/HEARING THERAPY                                                                                              | Carelon-https://providerportal.com/ or 866-455-8415                                                                                           | Rehabilitation (PT/OT/ST)                | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon                                | Carelon                                                                                                                                      | Change 8/1/2025           |                         |

| CPT and HCPCS Codes | Description of Procedure Code                                                                                                              | Medical Records Request Information Required                                       | Clinical Criteria Category               | Clinical Criteria Hierarchy                                 | Medical Policy Number                  | Medical Policy Name                                                                                                                                                 | Effective and Change Date | Date Posted to Website* |
|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|------------------------------------------|-------------------------------------------------------------|----------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------|
| 92511               | NASOPHARYNGOSCOPY                                                                                                                          | Recent history and physical, plan of care, and documentation of medical necessity. | Musculoskeletal                          | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | No Med Policy                          | No medical policy                                                                                                                                                   | Added prior to 9/1/2019   |                         |
| 92520               | LARYNGEAL FUNCTION STUDIES                                                                                                                 | Recent history and physical, plan of care, and documentation of medical necessity. | Musculoskeletal                          | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | MED204.004                             | Rhinomanometry, Acoustic Rhinometry, Optical Rhinometry and Acoustic Pharyngometry                                                                                  | Added prior to 9/1/2019   |                         |
| 92524               | BEHAVIORAL QUALITY ANALYSIS VOICE                                                                                                          | Carelon-https://providerportal.com/ or 866-455-8415                                | Rehabilitation (PT/OT/ST)                | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                                | Carelon                                                                                                                                                             | Change 8/1/2025           |                         |
| 92526               | ORAL FUNCTION THERAPY                                                                                                                      | Carelon-https://providerportal.com/ or 866-455-8415                                | Rehabilitation (PT/OT/ST)                | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                                | Carelon                                                                                                                                                             | Change 8/1/2025           |                         |
| 92548               | POSTUROGRAPHY                                                                                                                              | Recent history and physical, plan of care, and documentation of medical necessity. | Musculoskeletal                          | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | MED205.026                             | Dynamic Posturography                                                                                                                                               | 1/1/2020                  |                         |
| 92584               | ELECTROCOCHLEOGRAPHY                                                                                                                       | Recent history and physical, plan of care, and documentation of medical necessity. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR714.008                             | Semi-Implantable and Fully Implantable Middle Ear Hearing Aids                                                                                                      | Added prior to 9/1/2019   |                         |
| 92597               | ORAL SPEECH DEVICE EVAL                                                                                                                    | Recent history and physical, plan of care, and documentation of medical necessity. | Musculoskeletal                          | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | No Med Policy                          | No medical policy                                                                                                                                                   | Added prior to 9/1/2019   |                         |
| 92606               | NON-SPEECH DEVICE SERVICE                                                                                                                  | Carelon-https://providerportal.com/ or 866-455-8415                                | Rehabilitation (PT/OT/ST)                | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                                | Carelon                                                                                                                                                             | Change 8/1/2025           |                         |
| 92609               | USE OF SPEECH DEVICE SERVICE                                                                                                               | Carelon-https://providerportal.com/ or 866-455-8415                                | Rehabilitation (PT/OT/ST)                | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                                | Carelon                                                                                                                                                             | Change 8/1/2025           |                         |
| 92612               | ENDOSCOPY SWALLOW (FEES) VID                                                                                                               | Recent history and physical, plan of care, and documentation of medical necessity. | Musculoskeletal                          | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | No Med Policy                          | No medical policy                                                                                                                                                   | Added prior to 9/1/2019   |                         |
| 92613               | ENDOSCOPY SWALLOW (FEES) I&R                                                                                                               | Recent history and physical, plan of care, and documentation of medical necessity. | Musculoskeletal                          | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | No Med Policy                          | No medical policy                                                                                                                                                   | Added prior to 9/1/2019   |                         |
| 92614               | LARYNGOSCOPIC SENSORY VID                                                                                                                  | Recent history and physical, plan of care, and documentation of medical necessity. | Musculoskeletal                          | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | No Med Policy                          | No medical policy                                                                                                                                                   | Added prior to 9/1/2019   |                         |
| 92615               | LARYNGOSCOPIC SENSORY I&R                                                                                                                  | Recent history and physical, plan of care, and documentation of medical necessity. | Musculoskeletal                          | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | OTH903.025<br>SUR716.004               | Eyelid Thermal Pulsation Blepharoplasty, Blepharoptosis and Brow Repair                                                                                             | Added prior to 9/1/2019   |                         |
| 92616               | FEES W/LARYNGEAL SENSE TEST                                                                                                                | Recent history and physical, plan of care, and documentation of medical necessity. | Musculoskeletal                          | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | RAD601.053<br>PSY301.014               | Optical Coherence Tomography of the Breast Autism Spectrum Disorders                                                                                                | Added prior to 9/1/2019   |                         |
| 92617               | FEES W/LARYNGEAL SENSE I&R                                                                                                                 | Recent history and physical, plan of care, and documentation of medical necessity. | Musculoskeletal                          | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | MED204.005<br>MED202.057<br>MED204.006 | Diagnosis of Obstructive Sleep Apnea Syndrome Endovascular Stent Grafts for Disorders of the Thoracic Aorta Medical Management of Sleep Related Breathing Disorders | Added prior to 9/1/2019   |                         |
| 92630               | AUD REHAB PRE-LING HEAR LOSS                                                                                                               | Carelon-https://providerportal.com/ or 866-455-8415                                | Rehabilitation (PT/OT/ST)                | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                                | Carelon                                                                                                                                                             | Change 8/1/2025           |                         |
| 92633               | AUD REHAB POSTLING HEAR LOSS                                                                                                               | Carelon-https://providerportal.com/ or 866-455-8415                                | Rehabilitation (PT/OT/ST)                | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                                | Carelon                                                                                                                                                             | Change 8/1/2025           |                         |
| 93228               | REMOTE 30 DAY ECG REV/REPORT                                                                                                               | Recent history and physical, plan of care, and documentation of medical necessity. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | MED202.003                             | Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems)      | Added prior to 9/1/2019   |                         |
| 93229               | REMOTE 30 DAY ECG TECH SUPP                                                                                                                | Recent history and physical, plan of care, and documentation of medical necessity. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | MED202.003                             | Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems)      | Added prior to 9/1/2019   |                         |
| 94660               | POS AIRWAY PRESSURE CPAP                                                                                                                   | Recent history and physical, plan of care, and documentation of medical necessity. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | MED204.005                             | Diagnosis and Medical Management of Sleep Related Breathing Disorders                                                                                               | Added prior to 9/1/2019   |                         |
| 94667               | Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function, initial demonstration and /or evaluation. | Carelon-https://providerportal.com/ or 866-455-8415                                | Rehabilitation (PT/OT/ST)                | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                                | Carelon                                                                                                                                                             | Added 11/1/2025           | 9/1/2025                |
| 94668               | Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; subsequent.                               | Carelon-https://providerportal.com/ or 866-455-8415                                | Rehabilitation (PT/OT/ST)                | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                                | Carelon                                                                                                                                                             | Added 11/1/2025           | 9/1/2025                |
| 95782               | POLYSOM <6 YRS 4/> PARAMTRS                                                                                                                | Recent history and physical, plan of care, and documentation of medical necessity. | Sleep                                    | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | MED201.049<br>MED204.005               | Ploysomnography for Non-Respiratory Sleep Disorders Diagnosis of Obstructive Sleep Apnea Syndrome                                                                   | Added prior to 9/1/2019   |                         |
| 95783               | POLYSOM <6 YRS CPAP/BILVL                                                                                                                  | Recent history and physical, plan of care, and documentation of medical necessity. | Sleep                                    | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | MED201.049<br>MED204.006               | Ploysomnography for Non-Respiratory Sleep Disorders Diagnosis of Obstructive Sleep Apnea Syndrome                                                                   | Added prior to 9/1/2019   |                         |
| 95800               | SLP STDY UNATTENDED                                                                                                                        | Recent history and physical, plan of care, and documentation of medical necessity. | Sleep                                    | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | MED204.005<br>MED201.048               | Diagnosis of Obstructive Sleep Apnea Syndrome Actigraphy                                                                                                            | Added prior to 9/1/2019   |                         |
| 95801               | SLP STDY UNATND W/ANAL                                                                                                                     | Recent history and physical, plan of care, and documentation of medical necessity. | Sleep                                    | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | MED204.005                             | Diagnosis of Obstructive Sleep Apnea Syndrome                                                                                                                       | Added prior to 9/1/2019   |                         |
| 95803               | ACTIGRAPHY TESTING                                                                                                                         | Recent history and physical, plan of care, and documentation of medical necessity. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | MED201.048                             | Actigraphy                                                                                                                                                          | Added prior to 9/1/2019   |                         |
| 95805               | MULTIPLE SLEEP LATENCY TEST                                                                                                                | Recent history and physical, plan of care, and documentation of medical necessity. | Sleep                                    | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | MED201.049<br>MED204.005               | Ploysomnography for Non-Respiratory Sleep Disorders Diagnosis of Obstructive Sleep Apnea Syndrome                                                                   | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code                                                   | Medical Records Request Information Required                                                   | Clinical Criteria Category               | Clinical Criteria Hierarchy                                                                                                     | Medical Policy Number                  | Medical Policy Name                                                                                                                                                                                | Effective and Change Date | Date Posted to Website* |
|---------------------|---------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------|
| 95806               | SLEEP STUDY UNATT&RESP EFFT                                                     | Recent history and physical, plan of care, and documentation of medical necessity.             | Sleep                                    | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | MED204.005                             | Diagnosis of Obstructive Sleep Apnea Syndrome                                                                                                                                                      | Added prior to 9/1/2019   |                         |
| 95807               | SLEEP STUDY ATTENDED                                                            | Recent history and physical, plan of care, and documentation of medical necessity.             | Sleep                                    | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | MED204.005<br>MED204.006               | Diagnosis of Obstructive Sleep Apnea Syndrome<br>Medical Management of Sleep Related Breathing Disorders                                                                                           | Added prior to 9/1/2019   |                         |
| 95808               | POLYSOM ANY AGE 1-3> PARAM                                                      | Recent history and physical, plan of care, and documentation of medical necessity.             | Sleep                                    | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | MED201.049<br>MED204.005               | Polysomnography for Non-Respiratory Sleep Disorders<br>Diagnosis of Obstructive Sleep Apnea Syndrome                                                                                               | Added prior to 9/1/2019   |                         |
| 95810               | POLYSOM 6/> YRS 4/> PARAM                                                       | Recent history and physical, plan of care, and documentation of medical necessity.             | Sleep                                    | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | MED201.049<br>MED204.006               | Polysomnography for Non-Respiratory Sleep Disorders<br>Diagnosis of Obstructive Sleep Apnea Syndrome                                                                                               | Added prior to 9/1/2019   |                         |
| 95811               | POLYSOM 6/>YRS CPAP 4/> PARM                                                    | Recent history and physical, plan of care, and documentation of medical necessity.             | Sleep                                    | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | MED201.049<br>MED204.007               | Polysomnography for Non-Respiratory Sleep Disorders<br>Diagnosis of Obstructive Sleep Apnea Syndrome                                                                                               | Added prior to 9/1/2019   |                         |
| 95851               | RANGE OF MOTION MEASUREMENTS                                                    | Recent history and physical, plan of care, and documentation of medical necessity.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR705.010                             | Temporomandibular Joint (TMJ) Disorders (TMJD)                                                                                                                                                     | Added prior to 9/1/2019   |                         |
| 95852               | RANGE OF MOTION MEASUREMENTS                                                    | Recent history and physical, plan of care, and documentation of medical necessity.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | No Med Policy                          | No medical policy                                                                                                                                                                                  | Added prior to 9/1/2019   |                         |
| 96001               | Comprehensive computer-based motion analysis by video taping and 3D kinematics. | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 | Rehabilitation (PT/OT/ST)                | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                                | Carelon                                                                                                                                                                                            | Added 11/1/2025           | 9/1/2025                |
| 96040               | GENETIC COUNSELING 30 MIN                                                       | Recent history and physical, plan of care, and documentation of medical necessity.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | MED208.092<br>MED208.089               | Genetic Testing for BRCA1 or BRCA2 for Hereditary Breast and Ovarian Cancer Syndrome and Other High-Risk Cancers Genetic Testing for Mitochondrial Disorders                                       | Added prior to 9/1/2019   |                         |
| 96041               | Genetic Counseling                                                              | Recent history and physical, plan of care, and documentation of medical necessity.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | No Med Policy                          | No medical policy                                                                                                                                                                                  | 7/1/2025                  |                         |
| 96105               | ASSESSMENT OF APHASIA                                                           | Recent history and physical, plan of care, and documentation of medical necessity.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | PSY301.014<br>PSY301.020               | Psychological and Neuropsychological Testing<br>Autism Spectrum Disorders (ASD)                                                                                                                    | Added prior to 9/1/2019   |                         |
| 96112               | DEVEL TST PHYS/QHP 1ST HR                                                       | Recent history and physical, plan of care, and documentation of medical necessity.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | PSY301.014<br>PSY301.021               | Psychological and Neuropsychological Testing<br>Autism Spectrum Disorders (ASD)                                                                                                                    | Added prior to 9/1/2019   |                         |
| 96113               | DEVEL TST PHYS/QHP EA ADDL                                                      | Recent history and physical, plan of care, and documentation of medical necessity.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | PSY301.014<br>PSY301.022               | Psychological and Neuropsychological Testing<br>Autism Spectrum Disorders (ASD)                                                                                                                    | Added prior to 9/1/2019   |                         |
| 96125               | COGNITIVE TEST BY HC PRO                                                        | Recent history and physical, plan of care, and documentation of medical necessity.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | PSY301.014<br>PSY301.022               | Psychological and Neuropsychological Testing<br>Autism Spectrum Disorders (ASD)                                                                                                                    | Added prior to 9/1/2019   |                         |
| 97010               | HOT OR COLD PACKS THERAPY                                                       | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 | Rehabilitation (PT/OT/ST)                | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                                | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| 97012               | MECHANICAL TRACTION THERAPY                                                     | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 | Rehabilitation (PT/OT/ST)                | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                                | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| 97014               | ELECTRIC STIMULATION THERAPY                                                    | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 | Rehabilitation (PT/OT/ST)                | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                                | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| 97016               | VASOPNEUMATIC DEVICE THERAPY                                                    | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 | Rehabilitation (PT/OT/ST)                | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                                | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| 97018               | PARAFFIN BATH THERAPY                                                           | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 | Rehabilitation (PT/OT/ST)                | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                                | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| 97022               | WHIRLPOOL THERAPY                                                               | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 | Rehabilitation (PT/OT/ST)                | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                                | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| 97024               | DIATHERMY EG MICROWAVE                                                          | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 | Rehabilitation (PT/OT/ST)                | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                                | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| 97026               | INFRARED THERAPY                                                                | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 | Rehabilitation (PT/OT/ST)                | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                                | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| 97028               | ULTRAVIOLET THERAPY                                                             | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 | Rehabilitation (PT/OT/ST)                | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                                | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| 97032               | ELECTRICAL STIMULATION                                                          | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 | Rehabilitation (PT/OT/ST)                | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                                | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| 97033               | ELECTRIC CURRENT THERAPY                                                        | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 | Rehabilitation (PT/OT/ST)                | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                                | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| 97034               | CONTRAST BATH THERAPY                                                           | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 | Rehabilitation (PT/OT/ST)                | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                                | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| 97035               | ULTRASOUND THERAPY                                                              | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 | Rehabilitation (PT/OT/ST)                | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                                | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| 97036               | HYDROTHERAPY                                                                    | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 | Rehabilitation (PT/OT/ST)                | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                                | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| 97039               | PHYSICAL THERAPY TREATMENT                                                      | Recent history and physical, plan of care, and documentation of medical necessity.             | Rehabilitation (PT/OT/ST)                | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | MED201.057<br>THE803.010<br>THE803.008 | High Intensity Laser Therapy for Chronic Musculoskeletal Pain Conditions and Bell's Palsy<br>Physical Therapy (PT) and Occupational Therapy (OT) Services<br>Non-Covered Physical Therapy Services | 1/1/2020                  |                         |

| CPT and HCPCS Codes | Description of Procedure Code | Medical Records Request Information Required                                       | Clinical Criteria Category | Clinical Criteria Hierarchy                                 | Medical Policy Number    | Medical Policy Name                                                                                                         | Effective and Change Date | Date Posted to Website* |
|---------------------|-------------------------------|------------------------------------------------------------------------------------|----------------------------|-------------------------------------------------------------|--------------------------|-----------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------|
| 97110               | THERAPEUTIC EXERCISES         | Carelon-https://providerportal.com/ or 866-455-8415                                | Rehabilitation (PT/OT/ST)  | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                     | Change 8/1/2025           |                         |
| 97112               | NEUROMUSCULAR REEDUCATION     | Carelon-https://providerportal.com/ or 866-455-8415                                | Rehabilitation (PT/OT/ST)  | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                     | Change 8/1/2025           |                         |
| 97113               | AQUATIC THERAPY/EXERCISES     | Carelon-https://providerportal.com/ or 866-455-8415                                | Rehabilitation (PT/OT/ST)  | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                     | Change 8/1/2025           |                         |
| 97116               | GAIT TRAINING THERAPY         | Carelon-https://providerportal.com/ or 866-455-8415                                | Rehabilitation (PT/OT/ST)  | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                     | Change 8/1/2025           |                         |
| 97124               | MASSAGE THERAPY               | Carelon-https://providerportal.com/ or 866-455-8415                                | Rehabilitation (PT/OT/ST)  | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                     | Change 8/1/2025           |                         |
| 97140               | MANUAL THERAPY 1/> REGIONS    | Carelon-https://providerportal.com/ or 866-455-8415                                | Rehabilitation (PT/OT/ST)  | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                     | Change 8/1/2025           |                         |
| 97150               | GROUP THERAPEUTIC PROCEDURES  | Carelon-https://providerportal.com/ or 866-455-8415                                | Rehabilitation (PT/OT/ST)  | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                     | Change 8/1/2025           |                         |
| 97164               | PT RE-EVAL EST PLAN CARE      | Carelon-https://providerportal.com/ or 866-455-8415                                | Rehabilitation (PT/OT/ST)  | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                     | Change 11/1/2025          | 9/1/2025                |
| 97168               | OT RE-EVAL EST PLAN CARE      | Carelon-https://providerportal.com/ or 866-455-8415                                | Rehabilitation (PT/OT/ST)  | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                     | Change 8/1/2025           |                         |
| 97530               | THERAPEUTIC ACTIVITIES        | Carelon-https://providerportal.com/ or 866-455-8415                                | Rehabilitation (PT/OT/ST)  | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                     | Change 8/1/2025           |                         |
| 97533               | SENSORY INTEGRATION           | Carelon-https://providerportal.com/ or 866-455-8415                                | Rehabilitation (PT/OT/ST)  | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                     | Change 8/1/2025           |                         |
| 97535               | SELF CARE MNGMENT TRAINING    | Carelon-https://providerportal.com/ or 866-455-8415                                | Rehabilitation (PT/OT/ST)  | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                     | Change 8/1/2025           |                         |
| 97537               | COMMUNITY/WORK REINTEGRATION  | Carelon-https://providerportal.com/ or 866-455-8415                                | Rehabilitation (PT/OT/ST)  | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                     | Change 8/1/2025           |                         |
| 97542               | WHEELCHAIR MNGMENT TRAINING   | Carelon-https://providerportal.com/ or 866-455-8415                                | Rehabilitation (PT/OT/ST)  | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                     | Change 8/1/2025           |                         |
| 97545               | WORK HARDENING                | Carelon-https://providerportal.com/ or 866-455-8415                                | Rehabilitation (PT/OT/ST)  | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                     | Change 8/1/2025           |                         |
| 97546               | WORK HARDENING ADD-ON         | Carelon-https://providerportal.com/ or 866-455-8415                                | Rehabilitation (PT/OT/ST)  | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                     | Change 8/1/2025           |                         |
| 97597               | RMVL DEVITAL TIS 20 CM/<      | Recent history and physical, plan of care, and documentation of medical necessity. | Rehabilitation (PT/OT/ST)  | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | No Med Policy            | No medical policy                                                                                                           | 1/1/2020                  |                         |
| 97598               | RMVL DEVITAL TIS ADDL 20CM/<  | Recent history and physical, plan of care, and documentation of medical necessity. | Rehabilitation (PT/OT/ST)  | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | No Med Policy            | No medical policy                                                                                                           | 1/1/2020                  |                         |
| 97602               | WOUND(S) CARE NON-SELECTIVE   | Recent history and physical, plan of care, and documentation of medical necessity. | Rehabilitation (PT/OT/ST)  | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | No Med Policy            | No medical policy                                                                                                           | Added prior to 9/1/2019   |                         |
| 97605               | NEG PRESS WOUND TX </=50 CM   | Recent history and physical, plan of care, and documentation of medical necessity. | Rehabilitation (PT/OT/ST)  | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | DME101.036               | Negative Pressure Wound Therapy (NPWT) for the Treatment of Wounds                                                          | 1/1/2020                  |                         |
| 97606               | NEG PRESS WOUND TX >50 CM     | Recent history and physical, plan of care, and documentation of medical necessity. | Rehabilitation (PT/OT/ST)  | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | DME101.037               | Negative Pressure Wound Therapy (NPWT) for the Treatment of Wounds                                                          | 1/1/2020                  |                         |
| 97750               | PHYSICAL PERFORMANCE TEST     | Carelon-https://providerportal.com/ or 866-455-8415                                | Rehabilitation (PT/OT/ST)  | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                     | Change 8/1/2025           |                         |
| 97755               | ASSISTIVE TECHNOLOGY ASSESS   | Carelon-https://providerportal.com/ or 866-455-8415                                | Rehabilitation (PT/OT/ST)  | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                     | Change 8/1/2025           |                         |
| 97760               | ORTHOTIC MGMT&TRAINJ 1ST ENC  | Carelon-https://providerportal.com/ or 866-455-8415                                | Rehabilitation (PT/OT/ST)  | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                     | Change 8/1/2025           |                         |
| 97761               | PROSTHETIC TRAINJ 1ST ENC     | Carelon-https://providerportal.com/ or 866-455-8415                                | Rehabilitation (PT/OT/ST)  | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                     | Change 8/1/2025           |                         |
| 97763               | ORTHC/PROSTC MGMT SBSQ ENC    | Carelon-https://providerportal.com/ or 866-455-8415                                | Rehabilitation (PT/OT/ST)  | https://guidelines.carelonmedicalbenefitsmanagement.com/    | Carelon                  | Carelon                                                                                                                     | Change 8/1/2025           |                         |
| 97799               | PHYSICAL MEDICINE PROCEDURE   | Recent history and physical, plan of care, and documentation of medical necessity. | Musculoskeletal            | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | THE803.010               | Physical Therapy (PT) and Occupational Therapy (OT) Services                                                                | Added prior to 9/1/2019   |                         |
| 97810               | ACUPUNCT W/O STIMUL 15 MIN    | Recent history and physical, plan of care, and documentation of medical necessity. | Musculoskeletal            | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR702.005<br>MED201.030 | Acupuncture for Pain Management, Nausea and Vomiting and Opioid Dependence<br>Sexual Dysfunctions, Assessment and Treatment | Added prior to 9/1/2019   |                         |
| 98940               | CHIROPRACT MANJ 1-2 REGIONS   | Recent history and physical, plan of care, and documentation of medical necessity. | Musculoskeletal            | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | No Med Policy            | No medical policy                                                                                                           | Added prior to 9/1/2019   |                         |
| 98941               | CHIROPRACT MANJ 3-4 REGIONS   | Recent history and physical, plan of care, and documentation of medical necessity. | Musculoskeletal            | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | No Med Policy            | No medical policy                                                                                                           | Added prior to 9/1/2019   |                         |
| 98942               | CHIROPRACTIC MANJ 5 REGIONS   | Recent history and physical, plan of care, and documentation of medical necessity. | Musculoskeletal            | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | No Med Policy            | No medical policy                                                                                                           | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code   | Medical Records Request Information Required                                       | Clinical Criteria Category               | Clinical Criteria Hierarchy                                         | Medical Policy Number | Medical Policy Name              | Effective and Change Date | Date Posted to Website* |
|---------------------|---------------------------------|------------------------------------------------------------------------------------|------------------------------------------|---------------------------------------------------------------------|-----------------------|----------------------------------|---------------------------|-------------------------|
| 98943               | CHIROPRACT MANJ XTRSPINL 1/>    | Recent history and physical, plan of care, and documentation of medical necessity. | Musculoskeletal                          | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG         | No Med Policy         | No medical policy                | Added prior to 9/1/2019   |                         |
| 99183               | HYPERBARIC OXYGEN THERAPY       | Recent history and physical, plan of care, and documentation of medical necessity. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG         | THE801.003            | Hyperbaric Oxygen (HBO2) Therapy | 1/1/2020                  |                         |
| 99601               | HOME INFUSION/VISIT 2 HRS       | Recent history and physical, plan of care, and documentation of medical necessity. | Home Health - Home Infusion              | Illinois Medicaid Provider Manual, MCG, Medicare NCD/LCD Guidelines | No Med Policy         | No medical policy                | Added prior to 9/1/2019   |                         |
| 99602               | HOME INFUSION EACH ADDTL HR     | Recent history and physical, plan of care, and documentation of medical necessity. | Home Health - Home Infusion              | Illinois Medicaid Provider Manual, MCG, Medicare NCD/LCD Guidelines | No Med Policy         | No medical policy                | Added prior to 9/1/2019   |                         |
| 0004M               | SCO 53 SNPS                     | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                                      | https://guidelines.carelonmedicalbenefitsmanagement.com/            | Carelon               | Carelon                          | Change 8/1/2025           |                         |
| 0006M               | Onc hep gene risk classifier    | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                                      | https://guidelines.carelonmedicalbenefitsmanagement.com/            | Carelon               | Carelon                          | Change 8/1/2025           |                         |
| 0007M               | Onc gastro 51 gene nomogram     | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                                      | https://guidelines.carelonmedicalbenefitsmanagement.com/            | Carelon               | Carelon                          | Change 8/1/2025           |                         |
| 0011M               | ONC PRST8 CA MRNA 12 GEN ALG    | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                                      | https://guidelines.carelonmedicalbenefitsmanagement.com/            | Carelon               | Carelon                          | Change 8/1/2025           |                         |
| 0012M               | ONC MRNA 5 GEN RSK URTHL CA     | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                                      | https://guidelines.carelonmedicalbenefitsmanagement.com/            | Carelon               | Carelon                          | Change 8/1/2025           |                         |
| 0013M               | ONC MRNA 5 GEN RECR URTHL CA    | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                                      | https://guidelines.carelonmedicalbenefitsmanagement.com/            | Carelon               | Carelon                          | Change 8/1/2025           |                         |
| 0016M               | Onc bladder mrna 209 gen alg    | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                                      | https://guidelines.carelonmedicalbenefitsmanagement.com/            | Carelon               | Carelon                          | Change 8/1/2025           |                         |
| 0017M               | SARS-CoV-2                      | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                                      | https://guidelines.carelonmedicalbenefitsmanagement.com/            | Carelon               | Carelon                          | Change 8/1/2025           |                         |
| 0020M               | ONC CNS ALYS 30000 DNA LOCI     | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                                      | https://guidelines.carelonmedicalbenefitsmanagement.com/            | Carelon               | Carelon                          | Change 8/1/2025           |                         |
| 0037U               | TRGT GEN SEQ DNA 324 GENES      | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                                      | https://guidelines.carelonmedicalbenefitsmanagement.com/            | Carelon               | Carelon                          | Change 8/1/2025           |                         |
| 0042T               | B BRGDRFERI ANTb 12 PRTN IGG    | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                                | https://guidelines.carelonmedicalbenefitsmanagement.com/            | Carelon               | Carelon                          | Change 8/1/2025           |                         |
| 0069U               | ONC CLRCT MICRORNA MIR-31-3P    | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                                      | https://guidelines.carelonmedicalbenefitsmanagement.com/            | Carelon               | Carelon                          | Change 8/1/2025           |                         |
| 0070U               | CYP2D6 GEN COM&SLCT RAR VRNT    | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                                      | https://guidelines.carelonmedicalbenefitsmanagement.com/            | Carelon               | Carelon                          | Change 8/1/2025           |                         |
| 0095T               | RMVL ARTIFIC DISC ADDL CRVCL    | Carelon-https://providerportal.com/ or 866-455-8415                                | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/            | Carelon               | Carelon                          | Change 8/1/2025           |                         |
| 0101U               | HERED COLON CA DO 15 GENES      | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                                      | https://guidelines.carelonmedicalbenefitsmanagement.com/            | Carelon               | Carelon                          | Change 8/1/2025           |                         |
| 0102U               | HERED BRST CA RLTD DO 17 GEN    | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                                      | https://guidelines.carelonmedicalbenefitsmanagement.com/            | Carelon               | Carelon                          | Change 8/1/2025           |                         |
| 0103U               | HERED OVA CA PNL 24 GENES       | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                                      | https://guidelines.carelonmedicalbenefitsmanagement.com/            | Carelon               | Carelon                          | Change 8/1/2025           |                         |
| 0129U               | HERED BRST CA RLTD DO PANEL     | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                                      | https://guidelines.carelonmedicalbenefitsmanagement.com/            | Carelon               | Carelon                          | Change 8/1/2025           |                         |
| 0130U               | HERED COLON CA DO MRNA PNL      | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                                      | https://guidelines.carelonmedicalbenefitsmanagement.com/            | Carelon               | Carelon                          | Change 8/1/2025           |                         |
| 0131U               | HERED BRST CA RLTD DO PNL 13    | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                                      | https://guidelines.carelonmedicalbenefitsmanagement.com/            | Carelon               | Carelon                          | Change 8/1/2025           |                         |
| 0132U               | HERED OVA CA RLTD DO PNL 17     | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                                      | https://guidelines.carelonmedicalbenefitsmanagement.com/            | Carelon               | Carelon                          | Change 8/1/2025           |                         |
| 0133U               | HERED PRST8 CA RLTD DO 11       | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                                      | https://guidelines.carelonmedicalbenefitsmanagement.com/            | Carelon               | Carelon                          | Change 8/1/2025           |                         |
| 0134U               | HERED PAN CA MRNA PNL 18 GEN    | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                                      | https://guidelines.carelonmedicalbenefitsmanagement.com/            | Carelon               | Carelon                          | Change 8/1/2025           |                         |
| 0135U               | HERED GYN CA MRNA PNL 12 GEN    | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                                      | https://guidelines.carelonmedicalbenefitsmanagement.com/            | Carelon               | Carelon                          | Change 8/1/2025           |                         |
| 0162U               | Proprietary Laboratory Analyses | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                                      | https://guidelines.carelonmedicalbenefitsmanagement.com/            | Carelon               | Carelon                          | Change 11/1/2025          | 9/1/2025                |
| 0164T               | REMOVE LUMB ARTIF DISC ADDL     | Carelon-https://providerportal.com/ or 866-455-8415                                | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/            | Carelon               | Carelon                          | Change 8/1/2025           |                         |
| 0165T               | REVISE LUMB ARTIF DISC ADDL     | Carelon-https://providerportal.com/ or 866-455-8415                                | Musculoskeletal                          | https://guidelines.carelonmedicalbenefitsmanagement.com/            | Carelon               | Carelon                          | Change 8/1/2025           |                         |
| 0238U               | ONC LNCH SYN GEN DNA SEQ ALY    | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                                      | https://guidelines.carelonmedicalbenefitsmanagement.com/            | Carelon               | Carelon                          | Change 8/1/2025           |                         |

| CPT and HCPCS Codes | Description of Procedure Code              | Medical Records Request Information Required                                       | Clinical Criteria Category               | Clinical Criteria Hierarchy                                                        | Medical Policy Number | Medical Policy Name                               | Effective and Change Date | Date Posted to Website* |
|---------------------|--------------------------------------------|------------------------------------------------------------------------------------|------------------------------------------|------------------------------------------------------------------------------------|-----------------------|---------------------------------------------------|---------------------------|-------------------------|
| 0239U               | TRGT GEN SEQ ALYS PNL 311+                 | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                                      | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon               | Carelon                                           | Change 8/1/2025           |                         |
| 0340U               | Onc pan ca alys mrd plasma                 | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                                      | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon               | Carelon                                           | Change 8/1/2025           |                         |
| 0487U               | ONC SOL TUM CFCDNA TGSAP 84                | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                                      | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon               | Carelon                                           | Change 8/1/2025           |                         |
| 0493U               | TRNSPL MED QUAN DD-CFDNA NGS               | Carelon-https://providerportal.com/ or 866-455-8415                                | Lab                                      | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon               | Carelon                                           | Change 8/1/2025           |                         |
| 0537T               | Cellular Therapy Procedures Ancillary Code | Recent history and physical, plan of care, and documentation of medical necessity. | Outpatient Medical and surgical services | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines | RX502.061             | Oncology Medications                              | 1/1/2022                  |                         |
| 0538T               | Cellular Therapy Procedures Ancillary Code | Recent history and physical, plan of care, and documentation of medical necessity. | Outpatient Medical and surgical services | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines | RX502.061             | Oncology Medications                              | 1/1/2022                  |                         |
| 0539T               | Cellular Therapy Procedures Ancillary Code | Recent history and physical, plan of care, and documentation of medical necessity. | Outpatient Medical and surgical services | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines | RX502.061             | Oncology Medications                              | 1/1/2022                  |                         |
| 0540T               | Cellular Therapy Procedures Ancillary Code | Recent history and physical, plan of care, and documentation of medical necessity. | Outpatient Medical and surgical services | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines | RX502.061             | Oncology Medications                              | 1/1/2022                  |                         |
| 06029T              | Perq njx algc ct lmbr 1st                  | Recent history and physical, plan of care, and documentation of medical necessity. | Musculoskeletal                          | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines | SUR705.051            | Allograft Injection for Degenerative Disc Disease | 1/1/2021                  |                         |
| 0609T               | Mrs disc pain acquijs data                 | Recent history and physical, plan of care, and documentation of medical necessity. | Radiology                                | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines | No Med Policy         | No medical policy                                 | 1/1/2021                  |                         |
| 0610T               | Mrs disc pain transmis data                | Recent history and physical, plan of care, and documentation of medical necessity. | Radiology                                | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines | No Med Policy         | No medical policy                                 | 1/1/2021                  |                         |
| 0611T               | Mrs disc pain alg alys data                | Recent history and physical, plan of care, and documentation of medical necessity. | Radiology                                | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines | No Med Policy         | No medical policy                                 | 1/1/2021                  |                         |
| 0612T               | Mrs discogenic pain i&r                    | Recent history and physical, plan of care, and documentation of medical necessity. | Radiology                                | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines | No Med Policy         | No medical policy                                 | 1/1/2021                  |                         |
| 0627T               | Perq njx algc fluor lmbr 1st               | Recent history and physical, plan of care, and documentation of medical necessity. | Musculoskeletal                          | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines | SUR705.049            | Allograft Injection for Degenerative Disc Disease | 1/1/2021                  |                         |
| 0628T               | Perq njx algc fluor lmbr ea                | Recent history and physical, plan of care, and documentation of medical necessity. | Musculoskeletal                          | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines | SUR705.050            | Allograft Injection for Degenerative Disc Disease | 1/1/2021                  |                         |
| 0630T               | Perq njx algc ct lmbr ea                   | Recent history and physical, plan of care, and documentation of medical necessity. | Musculoskeletal                          | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines | SUR705.052            | Allograft Injection for Degenerative Disc Disease | 1/1/2021                  |                         |
| 0633T               | Ct breast w/3d uni c-                      | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                                | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon               | Carelon                                           | Change 8/1/2025           |                         |
| 0634T               | Ct breast w/3d uni c+                      | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                                | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon               | Carelon                                           | Change 8/1/2025           |                         |
| 0635T               | Ct breast w/3d uni c-/c+                   | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                                | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon               | Carelon                                           | Change 8/1/2025           |                         |
| 0636T               | Ct breast w/3d bi c-                       | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                                | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon               | Carelon                                           | Change 8/1/2025           |                         |
| 0637T               | Ct breast w/3d bi c+                       | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                                | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon               | Carelon                                           | Change 8/1/2025           |                         |
| 0638T               | Ct breast w/3d bi c-/c+                    | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                                | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon               | Carelon                                           | Change 8/1/2025           |                         |
| 0649T               | QUAN MR ALYS TISS W/MRI                    | Carelon-https://providerportal.com/ or 866-455-8415                                | Radiology                                | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon               | Carelon                                           | Change 8/1/2025           |                         |
| 0697T               | Quan mr tis wo mri mlt orgn                | Recent history and physical, plan of care, and documentation of medical necessity. | Radiology                                | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines | No Med Policy         | No medical policy                                 | 7/1/2021                  |                         |
| 0698T               | Quan mr tiss w/mri mlt orgn                | Recent history and physical, plan of care, and documentation of medical necessity. | Radiology                                | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines | No Med Policy         | No medical policy                                 | Added 10/1/2022           |                         |

| CPT and HCPCS Codes | Description of Procedure Code                                                           | Medical Records Request Information Required                                                                                              | Clinical Criteria Category | Clinical Criteria Hierarchy                                                                                       | Medical Policy Number | Medical Policy Name                                                      | Effective and Change Date | Date Posted to Website* |
|---------------------|-----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-------------------------------------------------------------------------------------------------------------------|-----------------------|--------------------------------------------------------------------------|---------------------------|-------------------------|
| 0711T               | N-nvs artl plaq alys dat prp                                                            | Recent history and physical, plan of care, and documentation of medical necessity.                                                        | Radiology                  | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                | RAD604.009            | Computed Tomography to Detect Coronary Artery Calcification              | Added 10/1/2022           |                         |
| 0712T               | N-nvs artl plaq alys quan                                                               | Recent history and physical, plan of care, and documentation of medical necessity.                                                        | Radiology                  | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                | RAD604.010            | Computed Tomography to Detect Coronary Artery Calcification              | Added 10/1/2022           |                         |
| 0713T               | N-nvs artl plaq alys rvw i&r                                                            | Recent history and physical, plan of care, and documentation of medical necessity.                                                        | Radiology                  | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                | RAD604.011            | Computed Tomography to Detect Coronary Artery Calcification              | Added 10/1/2022           |                         |
| 0784T               | Insertion or replacement of percutaneous electrode                                      | Recent history and physical, plan of care, and documentation of medical necessity.                                                        | Radiology                  | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                | MED201.056            | Removal of Ascities via Implantable Pump                                 | Added 10/1/2022           |                         |
| 0785T               | Revision or removal of neurostimulator                                                  | Recent history and physical, plan of care, and documentation of medical necessity.                                                        | Radiology                  | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                | SUR712.009            | Spinal Cord Stimulation (SCS) and Dorsal Root Ganglion (DRG) Stimulation | 1/1/2024                  |                         |
| 0865T               | MRI Brain analysis                                                                      | Recent history and physical, plan of care, and documentation of medical necessity.                                                        | Radiology                  | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                | No Med Policy         | No medical policy                                                        | 1/1/2024                  |                         |
| 0866T               | MRI Brain analysis                                                                      | Recent history and physical, plan of care, and documentation of medical necessity.                                                        | Radiology                  | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                | No Med Policy         | No medical policy                                                        | Added 4/1/2024            |                         |
| A0430               | AMBULANCE SERVICE, CONVENTIONAL AIR SERVICES, TRANSPORT, ONE WAY (FIXED WING)           | Submit progress notes for last 24 hours prior to transport, physician order including medical records supporting rationale for transport. | Ambulance                  | Illinois Medicaid Transportation Services Provider Handbook, BCBS Medical Policy                                  | ADM1001.005           | Ambulance and Medical Transport Services                                 | Added prior to 9/1/2019   |                         |
| A0431               | AMBULANCE SERVICE, CONVENTIONAL AIR SERVICES, TRANSPORT, ONE WAY (ROTARY WING)          | Submit progress notes for last 24 hours prior to transport, physician order including medical records supporting rationale for transport. | Ambulance                  | Illinois Medicaid Transportation Services Provider Handbook, BCBS Medical Policy                                  | ADM1001.005           | Ambulance and Medical Transport Services                                 | Added prior to 9/1/2019   |                         |
| A4604               | Tubing with integrated heating element for use with positive airway pressure device     | Recent history and physical, plan of care, and documentation of medical necessity.                                                        | Sleep                      | Illinois Medicaid Provider Manual, Illinois Administrative Code, BCBS Medical Policy, Medicare NCD/LCD Guidelines | MED204.006            | Medical Management of Sleep Related Breathing Disorders                  | Added prior to 9/1/2019   |                         |
| A4649               | SURGICAL SUPPLY; MISCELLANEOUS                                                          | Letter of medical necessity, including condition being treated.                                                                           | DME                        | Illinois Medicaid Provider Manual, Illinois Administrative Code, BCBS Medical Policy, Medicare NCD/LCD Guidelines | No Med Policy         | No medical policy                                                        | Added 1/1/23              |                         |
| A7027               | Combination oral/nasal mask, used with continuous positive airway pressure device, each | Letter of medical necessity, including condition being treated.                                                                           | Sleep                      | Illinois Medicaid Provider Manual, Illinois Administrative Code, BCBS Medical Policy, Medicare NCD/LCD Guidelines | MED204.006            | Medical Management of Sleep Related Breathing Disorders                  | Added prior to 9/1/2019   |                         |
| A7028               | Oral cushion for combination oral/nasal mask, replacement only, each                    | Letter of medical necessity, including condition being treated.                                                                           | Sleep                      | Illinois Medicaid Provider Manual, Illinois Administrative Code, BCBS Medical Policy, Medicare NCD/LCD Guidelines | MED204.006            | Medical Management of Sleep Related Breathing Disorders                  | Added prior to 9/1/2019   |                         |
| A7029               | Nasal pillows for combination oral/nasal mask, replacement only, pair                   | Letter of medical necessity, including condition being treated.                                                                           | Sleep                      | Illinois Medicaid Provider Manual, Illinois Administrative Code, BCBS Medical Policy, Medicare NCD/LCD Guidelines | MED204.006            | Medical Management of Sleep Related Breathing Disorders                  | Added prior to 9/1/2019   |                         |
| A7030               | Full face mask used with positive airway pressure device, each                          | Letter of medical necessity, including condition being treated.                                                                           | Sleep                      | Illinois Medicaid Provider Manual, Illinois Administrative Code, BCBS Medical Policy, Medicare NCD/LCD Guidelines | MED204.006            | Medical Management of Sleep Related Breathing Disorders                  | Added prior to 9/1/2019   |                         |
| A7031               | Face mask interface, replacement for full face mask, each                               | Letter of medical necessity, including condition being treated.                                                                           | Sleep                      | Illinois Medicaid Provider Manual, Illinois Administrative Code, BCBS Medical Policy, Medicare NCD/LCD Guidelines | MED204.006            | Medical Management of Sleep Related Breathing Disorders                  | Added prior to 9/1/2019   |                         |
| A7032               | Cushion for use on nasal mask interface, replacement only, each                         | Letter of medical necessity, including condition being treated.                                                                           | Sleep                      | Illinois Medicaid Provider Manual, Illinois Administrative Code, BCBS Medical Policy, Medicare NCD/LCD Guidelines | MED204.006            | Medical Management of Sleep Related Breathing Disorders                  | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code                                                                                | Medical Records Request Information Required                                                   | Clinical Criteria Category | Clinical Criteria Hierarchy                                                                                                     | Medical Policy Number | Medical Policy Name                                               | Effective and Change Date | Date Posted to Website* |
|---------------------|--------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|----------------------------|---------------------------------------------------------------------------------------------------------------------------------|-----------------------|-------------------------------------------------------------------|---------------------------|-------------------------|
| A7033               | Pillow for use on nasal cannula type interface, replacement only, pair                                       | Letter of medical necessity, including condition being treated.                                | Sleep                      | Illinois Medicaid Provider Manual, Illinois Administrative Code, BCBS Medical Policy, Medicare NCD/LCD Guidelines               | MED204.006            | Medical Management of Sleep Related Breathing Disorders           | Added prior to 9/1/2019   |                         |
| A7034               | Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head strap | Letter of medical necessity, including condition being treated.                                | Sleep                      | Illinois Medicaid Provider Manual, Illinois Administrative Code, BCBS Medical Policy, Medicare NCD/LCD Guidelines               | MED204.006            | Medical Management of Sleep Related Breathing Disorders           | Added prior to 9/1/2019   |                         |
| A7035               | Headgear used with positive airway pressure device                                                           | Letter of medical necessity, including condition being treated.                                | Sleep                      | Illinois Medicaid Provider Manual, Illinois Administrative Code, BCBS Medical Policy, Medicare NCD/LCD Guidelines               | MED204.006            | Medical Management of Sleep Related Breathing Disorders           | Added prior to 9/1/2019   |                         |
| A7036               | Chinstrap used with positive airway pressure device                                                          | Letter of medical necessity, including condition being treated.                                | Sleep                      | Illinois Medicaid Provider Manual, Illinois Administrative Code, BCBS Medical Policy, Medicare NCD/LCD Guidelines               | MED204.006            | Medical Management of Sleep Related Breathing Disorders           | Added prior to 9/1/2019   |                         |
| A7037               | Tubing used with positive airway pressure device                                                             | Letter of medical necessity, including condition being treated.                                | Sleep                      | Illinois Medicaid Provider Manual, Illinois Administrative Code, BCBS Medical Policy, Medicare NCD/LCD Guidelines               | MED204.006            | Medical Management of Sleep Related Breathing Disorders           | Added prior to 9/1/2019   |                         |
| A7038               | Filter, disposable, used with positive airway pressure device                                                | Letter of medical necessity, including condition being treated.                                | Sleep                      | Illinois Medicaid Provider Manual, Illinois Administrative Code, BCBS Medical Policy, Medicare NCD/LCD Guidelines               | MED204.006            | Medical Management of Sleep Related Breathing Disorders           | Added prior to 9/1/2019   |                         |
| A7039               | Filter, non disposable, used with positive airway pressure device                                            | Letter of medical necessity, including condition being treated.                                | Sleep                      | Illinois Medicaid Provider Manual, Illinois Administrative Code, BCBS Medical Policy, Medicare NCD/LCD Guidelines               | MED204.006            | Medical Management of Sleep Related Breathing Disorders           | Added prior to 9/1/2019   |                         |
| A7044               | Oral interface used with positive airway pressure device, each                                               | Letter of medical necessity, including condition being treated.                                | Sleep                      | Illinois Medicaid Provider Manual, Illinois Administrative Code, BCBS Medical Policy, Medicare NCD/LCD Guidelines               | MED204.006            | Medical Management of Sleep Related Breathing Disorders           | Added prior to 9/1/2019   |                         |
| A7045               | Exhalation port with or without swivel used with accessories for positive airway devices, replacement only   | Letter of medical necessity, including condition being treated.                                | Sleep                      | Illinois Medicaid Provider Manual, Illinois Administrative Code, BCBS Medical Policy, Medicare NCD/LCD Guidelines               | MED204.006            | Medical Management of Sleep Related Breathing Disorders           | Added prior to 9/1/2019   |                         |
| A7046               | Water chamber for humidifier, used with positive airway pressure device, replacement, each                   | Letter of medical necessity, including condition being treated.                                | Sleep                      | Illinois Medicaid Provider Manual, Illinois Administrative Code, BCBS Medical Policy, Medicare NCD/LCD Guidelines               | MED204.006            | Medical Management of Sleep Related Breathing Disorders           | Added prior to 9/1/2019   |                         |
| A9270               | Non-covered item or service                                                                                  | Letter of medical necessity, including condition being treated.                                | Sleep                      |                                                                                                                                 | No Med Policy         | No medical policy                                                 | 1/1/2019                  |                         |
| A9513               | Lutetium Lu 177 Dotatate Therapeutic 1 Millicurie                                                            | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 | Radiation Therapy          | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                           | Change 8/1/2025           |                         |
| A9528               | Iodine I-131 iodide cap, dx                                                                                  | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 | Radiation Therapy          | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                           | Change 8/1/2025           |                         |
| A9531               | I131 max 100uCi                                                                                              | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 | Radiation Therapy          | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                           | Change 8/1/2025           |                         |
| A9543               | Yttrium Y-90 Ibritumomab Tiuxetan Therapeutic Per Treatment Dose Up To 40 Millicuries                        | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 | Radiation Therapy          | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                           | Change 8/1/2025           |                         |
| A9606               | Radium Ra-223 Dichloride Therapeutic Per Microcurie                                                          | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 | Radiation Therapy          | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                           | Change 8/1/2025           |                         |
| A9607               | lutetium lu 177 vipivotide                                                                                   | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 | Radiation Therapy          | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                           | Change 8/1/2025           |                         |
| A9900               | MISCELLANEOUS SUPPLY, ACCESSORY, AND/OR SERVICE COMPONENT OF ANOTHER HCPCS CODE                              | Letter of medical necessity, including condition being treated.                                | DME                        | Illinois Medicaid Provider Manual, MCG, Medicare NCD/LCD Guidelines, Medical Policy                                             | No Med Policy         | No medical policy                                                 | Added 1/1/23              |                         |
| A9901               | DELIVERY/SET UP/DISPENSING                                                                                   | Letter of medical necessity, including condition being treated.                                | LTSS                       | Illinois Administrative Code                                                                                                    | No Med Policy         | Unable to crosswalk unspecified codes to specific medical policy. | Added 7/1/25              |                         |

| CPT and HCPCS Codes | Description of Procedure Code                                                                                                                                                                            | Medical Records Request Information Required                                                   | Clinical Criteria Category | Clinical Criteria Hierarchy                                                                                                     | Medical Policy Number | Medical Policy Name | Effective and Change Date | Date Posted to Website* |
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| A9999               | MISCELLANEOUS DME SUPPLY OR ACCESSORY, NOT OTHERWISE SPECIFIED                                                                                                                                           | Letter of medical necessity, including condition being treated.                                | DME                        | Illinois Medicaid Provider Manual, MCG, Medicare NCD/LCD Guidelines, Medical Policy                                             | No Med Policy         | No medical policy   | Added 1/1/23              |                         |
| B4161               | Enteral formula, for pediatrics; hydrolyzed/amino acids and peptide chain proteins, includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube | Letter of medical necessity, including condition being treated.                                | Home Health                | Illinois Medicaid Provider Manual, MCG, Medicare NCD/LCD Guidelines, Medical Policy                                             | MED201.011            | Nutritional Support | Added prior to 9/1/2019   |                         |
| B9998               | ENTERAL SUPPLIES; NOT OTHERWISE CLASSIFIED                                                                                                                                                               | Letter of medical necessity, including condition being treated.                                | Home Health                | Illinois Medicaid Provider Manual, MCG, Medicare NCD/LCD Guidelines, Medical Policy                                             | MED201.011            | Nutritional Support | Added 1/1/23              |                         |
| C8900               | Magnetic resonance angiography with contrast, abdomen                                                                                                                                                    | Recent history and physical, plan of care, and documentation of medical necessity.             | Radiology                  | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | No Med Policy         | No medical policy   | Added prior to 9/1/2019   |                         |
| C8901               | Magnetic resonance angiography without contrast, abdomen                                                                                                                                                 | Recent history and physical, plan of care, and documentation of medical necessity.             | Radiology                  | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | No Med Policy         | No medical policy   | Added prior to 9/1/2019   |                         |
| C8902               | Magnetic resonance angiography without contrast followed by with contrast, abdomen                                                                                                                       | Recent history and physical, plan of care, and documentation of medical necessity.             | Radiology                  | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | No Med Policy         | No medical policy   | Added prior to 9/1/2019   |                         |
| C8903               | Magnetic resonance imaging with contrast, breast; unilateral                                                                                                                                             | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 | Radiology                  | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon             | Change 8/1/2025           |                         |
| C8905               | Magnetic resonance imaging without contrast followed by with contrast, breast; unilateral                                                                                                                | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 | Radiology                  | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon             | Change 8/1/2025           |                         |
| C8906               | Magnetic resonance imaging with contrast, breast; bilateral                                                                                                                                              | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 | Radiology                  | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon             | Change 8/1/2025           |                         |
| C8908               | Magnetic resonance imaging without contrast followed by with contrast, breast; bilateral                                                                                                                 | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 | Radiology                  | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon             | Change 8/1/2025           |                         |
| C8909               | Magnetic resonance angiography with contrast, chest (excluding myocardium)                                                                                                                               | Recent history and physical, plan of care, and documentation of medical necessity.             | Radiology                  | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | No Med Policy         | No medical policy   | Added prior to 9/1/2019   |                         |
| C8910               | Magnetic resonance angiography without contrast, chest (excluding myocardium)                                                                                                                            | Recent history and physical, plan of care, and documentation of medical necessity.             | Radiology                  | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | No Med Policy         | No medical policy   | Added prior to 9/1/2019   |                         |
| C8911               | Magnetic resonance angiography without contrast followed by with contrast, chest (excluding myocardium)                                                                                                  | Recent history and physical, plan of care, and documentation of medical necessity.             | Radiology                  | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | No Med Policy         | No medical policy   | Added prior to 9/1/2019   |                         |
| C8912               | Magnetic resonance angiography with contrast, lower extremity                                                                                                                                            | Recent history and physical, plan of care, and documentation of medical necessity.             | Radiology                  | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | No Med Policy         | No medical policy   | Added prior to 9/1/2019   |                         |
| C8913               | Magnetic resonance angiography without contrast, lower extremity                                                                                                                                         | Recent history and physical, plan of care, and documentation of medical necessity.             | Radiology                  | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | No Med Policy         | No medical policy   | Added prior to 9/1/2019   |                         |
| C8914               | Magnetic resonance angiography without contrast followed by with contrast, lower extremity                                                                                                               | Recent history and physical, plan of care, and documentation of medical necessity.             | Radiology                  | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | No Med Policy         | No medical policy   | Added prior to 9/1/2019   |                         |
| C8918               | Magnetic resonance angiography with contrast, pelvis                                                                                                                                                     | Recent history and physical, plan of care, and documentation of medical necessity.             | Radiology                  | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | No Med Policy         | No medical policy   | Added prior to 9/1/2019   |                         |
| C8919               | Magnetic resonance angiography without contrast, pelvis                                                                                                                                                  | Recent history and physical, plan of care, and documentation of medical necessity.             | Radiology                  | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | No Med Policy         | No medical policy   | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code                                                                                                                                                                                                                                   | Medical Records Request Information Required                                                   | Clinical Criteria Category | Clinical Criteria Hierarchy                                                                                                     | Medical Policy Number | Medical Policy Name                                     | Effective and Change Date | Date Posted to Website* |
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| C8920               | Magnetic resonance angiography without contrast followed by with contrast, pelvis                                                                                                                                                                               | Recent history and physical, plan of care, and documentation of medical necessity.             | Radiology                  | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | No Med Policy         | No medical policy                                       | Added prior to 9/1/2019   |                         |
| C8931               | Magnetic resonance angiography with contrast, spinal canal and contents                                                                                                                                                                                         | Recent history and physical, plan of care, and documentation of medical necessity.             | Radiology                  | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | No Med Policy         | No medical policy                                       | Added prior to 9/1/2019   |                         |
| C8932               | Magnetic resonance angiography without contrast, spinal canal and contents                                                                                                                                                                                      | Recent history and physical, plan of care, and documentation of medical necessity.             | Radiology                  | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | No Med Policy         | No medical policy                                       | Added prior to 9/1/2019   |                         |
| C8933               | Magnetic resonance angiography without contrast followed by with contrast, spinal canal and contents                                                                                                                                                            | Recent history and physical, plan of care, and documentation of medical necessity.             | Radiology                  | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | No Med Policy         | No medical policy                                       | Added prior to 9/1/2019   |                         |
| C9047               | Injection, caplacizumab-yhdp, 1 mg                                                                                                                                                                                                                              | Recent history and physical, plan of care, and documentation of medical necessity.             | Medical Drug               | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | No Med Policy         | No medical policy                                       | Change 11/1/2025          | 9/1/2025                |
| C9076               | Lisocabtagene maraleucel                                                                                                                                                                                                                                        | Recent history and physical, plan of care, and documentation of medical necessity.             | Medical Drug               | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | RX502.061             | Oncology Medications                                    | 1/1/2022                  |                         |
| C9081               | Idcabtagene vicleucel                                                                                                                                                                                                                                           | Recent history and physical, plan of care, and documentation of medical necessity.             | Medical Drug               | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | RX502.061             | Oncology Medications                                    | 1/1/2022                  |                         |
| C9257               | Injection, bevacizumab, 0.25 mg                                                                                                                                                                                                                                 | Recent history and physical, plan of care, and documentation of medical necessity.             | Medical Drug               | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | No Med Policy         | No medical policy                                       | Change 11/1/2025          | 9/1/2025                |
| C9399               | Unclassified drugs or biologicals related to Car-T                                                                                                                                                                                                              | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                 | Change 8/1/2025           |                         |
| C9757               | Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and excision of herniated intervertebral disc, and repair of annular defect with implantation of bone anchored annular closure device, including | Recent history and physical, plan of care, and documentation of medical necessity.             | Musculoskeletal            | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | SUR705.045            | Annulus Closure After Discectomy                        | 9/1/2020                  |                         |
| C9791               | Mri hyperpolarized xenon129                                                                                                                                                                                                                                     | Recent history and physical, plan of care, and documentation of medical necessity.             | Radiology                  | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | No Med Policy         | No medical policy                                       | Added 4/1/2024            |                         |
| E0466               | home ventilator any type                                                                                                                                                                                                                                        | Letter of medical necessity, including condition being treated.                                | DME                        | Illinois Medicaid Provider Manual, MCG, Medicare NCD/LCD Guidelines, Medical Policy                                             | No Med Policy         | No medical policy                                       | Added 1/1/23              |                         |
| E0470               | Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)                                  | Recent history and physical, plan of care, and documentation of medical necessity              | Sleep                      | Illinois Medicaid Provider Manual, Illinois Administrative Code, BCBS Medical Policy, Medicare NCD/LCD Guidelines               | MED204.006            | Medical Management of Sleep Related Breathing Disorders | Added prior to 9/1/2019   |                         |
| E0471               | Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)                                    | Recent history and physical, plan of care, and documentation of medical necessity              | Sleep                      | Illinois Medicaid Provider Manual, Illinois Administrative Code, BCBS Medical Policy, Medicare NCD/LCD Guidelines               | MED204.006            | Medical Management of Sleep Related Breathing Disorders | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code                                                                                                                      | Medical Records Request Information Required                                                   | Clinical Criteria Category | Clinical Criteria Hierarchy                                                                                                     | Medical Policy Number                    | Medical Policy Name                                                                                                                               | Effective and Change Date | Date Posted to Website* |
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| E0485               | Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, prefabricated, includes fitting and adjustment     | Recent history and physical, plan of care,and documentation of medical necessity               | Sleep                      | Illinois Medicaid Provider Manual,Illinois Administrative Code, BCBS Medical Policy, Medicare NCD/LCD Guidelines                | MED204.006                               | Medical Management of Sleep Related Breathing Disorders                                                                                           | 9/1/2020                  |                         |
| E0486               | Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, custom fabricated, includes fitting and adjustment | Recent history and physical, plan of care,and documentation of medical necessity               | Sleep                      | Illinois Medicaid Provider Manual,Illinois Administrative Code, BCBS Medical Policy, Medicare NCD/LCD Guidelines                | MED204.006                               | Medical Management of Sleep Related Breathing Disorders                                                                                           | 9/1/2020                  |                         |
| E0492               | Control unit nm stim w phone                                                                                                                       | Recent history and physical, plan of care,and documentation of medical necessity               | Sleep                      | Illinois Medicaid Provider Manual,Illinois Administrative Code, BCBS Medical Policy, Medicare NCD/LCD Guidelines                | MED204.006                               | Medical Management of Sleep Related Breathing Disorders                                                                                           | 7/1/2024                  |                         |
| E0493               | Oral dv/app neuromus mouthpi                                                                                                                       | Recent history and physical, plan of care,and documentation of medical necessity               | Sleep                      | Illinois Medicaid Provider Manual,Illinois Administrative Code, BCBS Medical Policy, Medicare NCD/LCD Guidelines                | MED204.006                               | Medical Management of Sleep Related Breathing Disorders                                                                                           | 7/1/2024                  |                         |
| E0561               | Humidifier, non-heated, used with positive airway pressure device                                                                                  | Recent history and physical, plan of care,and documentation of medical necessity               | Sleep                      | Illinois Medicaid Provider Manual,Illinois Administrative Code, BCBS Medical Policy, Medicare NCD/LCD Guidelines                | MED204.006                               | Medical Management of Sleep Related Breathing Disorders                                                                                           | Added prior to 9/1/2019   |                         |
| E0562               | Humidifier, heated, used with positive airway pressure device                                                                                      | Recent history and physical, plan of care,and documentation of medical necessity               | Sleep                      | Illinois Medicaid Provider Manual,Illinois Administrative Code, BCBS Medical Policy, Medicare NCD/LCD Guidelines                | MED204.006                               | Medical Management of Sleep Related Breathing Disorders                                                                                           | Added prior to 9/1/2019   |                         |
| E0601               | Continuous positive airway pressure (cpap) device                                                                                                  | Recent history and physical, plan of care,and documentation of medical necessity               | Sleep                      | Illinois Medicaid Provider Manual,Illinois Administrative Code, BCBS Medical Policy, Medicare NCD/LCD Guidelines                | MED204.006                               | Medical Management of Sleep Related Breathing Disorders                                                                                           | Added prior to 9/1/2019   |                         |
| E0747               | OSTEOGENESIS STIMULATOR, ELECTRICAL, NON-INVASIVE, OTHER THAN SPINAL APPLICATIONS                                                                  | Letter of medical necessity, including condition being treated.                                | DME                        | Illinois Medicaid Provider Manual, MCG, Medicare NCD/LCD Guidelines, Medical Policy                                             | SUR705.044                               | Electrical Bone Growth Stimulation of the Appendicular Skeleton                                                                                   | Added 1/1/23              |                         |
| E0747               | OSTEOGENESIS STIMULATOR, ELECTRICAL, NON-INVASIVE, OTHER THAN SPINAL APPLICATIONS                                                                  | Letter of medical necessity, including condition being treated.                                | DME                        | Illinois Medicaid Provider Manual, MCG, Medicare NCD/LCD Guidelines, Medical Policy                                             | SUR705.044                               | Electrical Bone Growth Stimulation of the Appendicular Skeleton                                                                                   | Added 1/1/23              |                         |
| E0748               | Osteogenesis stimulator, electrical, non-invasive, spinal applications                                                                             | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 | Musculoskeletal            | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                                  | Carelon                                                                                                                                           | Change 8/1/2025           |                         |
| E0749               | Osteogenesis stimulator, electrical, surgically implanted                                                                                          | Letter of medical necessity, including condition being treated.                                | Musculoskeletal            | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR705.013<br>SUR705.044                 | Electrical Stimulation of the Spine as and Adjunct to Spinal Fusion Procedures<br>Electrical Bone Growth Stimulation of the Appendicular Skeleton | Added prior to 9/1/2019   |                         |
| E0760               | OSTEOGENESIS STIMULATOR, LOW INTENSITY ULTRASOUND, NON-INVASIVE                                                                                    | Letter of medical necessity, including condition being treated.                                | DME                        | Illinois Medicaid Provider Manual, MCG, Medicare NCD/LCD Guidelines, Medical Policy                                             | DME101.030                               | Low Intensity Pulsed Ultrasound Fracture Healing Device                                                                                           | Added 1/1/23              |                         |
| E1007               | WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, COMBINATION TILT AND RECLINE, WITHMECHANICAL SHEAR REDUCTION                                           | Letter of medical necessity, including condition being treated.                                | DME                        | Illinois Medicaid Provider Manual, MCG, Medicare NCD/LCD Guidelines, Medical Policy                                             | DME101.010                               | Wheelchairs and Accessories                                                                                                                       | Added 1/1/23              |                         |
| E1230               | POWER-OPERATED VEHICLE (3 OR 4 WHEEL NON-HIGHWAY) SPECIFY BRAND NAME AND MODEL NUMBER                                                              | Letter of medical necessity, including condition being treated.                                | DME                        | Illinois Medicaid Provider Manual, MCG, Medicare NCD/LCD Guidelines, Medical Policy                                             | DMIE101.010                              | Wheelchairs and Accessories                                                                                                                       | Added 1/1/23              |                         |
| E1399               | DURABLE MEDICAL EQUIPMENT, MISCELLANEOUS                                                                                                           | Letter of medical necessity, including condition being treated.                                | DME                        | Illinois Medicaid Provider Manual, MCG, Medicare NCD/LCD Guidelines, Medical Policy                                             | MED201.041,<br>PSY302.002,<br>PSY301.023 | Interferential Current Stimulation<br>Digital Health Thearpies for Substance Abuse<br>Digital Health Therapies for Chronic Insomnia               | Added 1/1/23              |                         |
| E2510               | SPEECH GENERATING DEVICE, SYNTHESIZED SPEECH, PERMITTING MULTIPLE METHODS OFMESSAGE FORMULATION AND MULTIPLE METHODS OF DEVICE ACCESS              | Letter of medical necessity, including condition being treated.                                | DME                        | Illinois Medicaid Provider Manual, MCG, Medicare NCD/LCD Guidelines, Medical Policy                                             | DME104.009                               | Speech Generating Devices                                                                                                                         | Added 1/1/23              |                         |

| CPT and HCPCS Codes | Description of Procedure Code                                                                                                                                                                                      | Medical Records Request Information Required                                                                                                   | Clinical Criteria Category | Clinical Criteria Hierarchy                                                         | Medical Policy Number          | Medical Policy Name                                                                                   | Effective and Change Date | Date Posted to Website* |
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| E2599               | ACCESSORY FOR SPEECH GENERATING DEVICE, NOT OTHERWISE CLASSIFIED                                                                                                                                                   | Letter of medical necessity, including condition being treated.                                                                                | DME                        | Illinois Medicaid Provider Manual, MCG, Medicare NCD/LCD Guidelines, Medical Policy | DME104.009                     | Speech Generating Devices                                                                             | Added 1/1/23              |                         |
| G0151               | Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes                                                                                                        | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity, including condition being treated. | Home Health Hospice        | Illinois Medicaid Provider Manual, MCG, Medicare NCD/LCD Guidelines                 | THE803.010                     | Physical Therapy (PT) and Occupational Therapy (OT) Services                                          | Added prior to 9/1/2019   |                         |
| G0152               | Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes                                                                                                    | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity, including condition being treated. | Home Health Hospice        | Illinois Medicaid Provider Manual, MCG, Medicare NCD/LCD Guidelines                 | THE803.010                     | Physical Therapy (PT) and Occupational Therapy (OT) Services                                          | Added prior to 9/1/2019   |                         |
| G0153               | SERVICES PERFORMED BY A QUALIFIED SPEECH-LANGUAGE PATHOLOGIST IN THE HOME HEALTH OR HOSPICE SETTING, EACH 15 MINUTES                                                                                               | Recent history and physical, plan of care, and documentation of medical necessity.                                                             | Home Health Hospice        | Illinois Medicaid Provider Manual, MCG, Medicare NCD/LCD Guidelines                 | THE803.014                     | Speech-Language Therapy (SLT)                                                                         | Added prior to 9/1/2019   |                         |
| G0155               | Services of clinical social worker in home health or hospice settings, each 15 minutes                                                                                                                             | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity, including condition being treated. | Home Health Hospice        | Illinois Medicaid Provider Manual, MCG, Medicare NCD/LCD Guidelines                 | No Med Policy                  | No medical policy                                                                                     | Added prior to 9/1/2019   |                         |
| G0156               | Services of home health/hospice aide in home health or hospice settings, each 15 minutes                                                                                                                           | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity, including condition being treated. | Home Health Hospice        | Illinois Medicaid Provider Manual, MCG, Medicare NCD/LCD Guidelines                 | No Med Policy                  | No medical policy                                                                                     | Added prior to 9/1/2019   |                         |
| G0157               | Services performed by a qualified physical therapist assistant in the home health or hospice setting, each 15 minutes                                                                                              | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity, including condition being treated. | Home Health Hospice        | Illinois Medicaid Provider Manual, MCG, Medicare NCD/LCD Guidelines                 | PSY301.014 - Delete THE803.010 | Autism Spectrum Disorders (ASD) - Delete Physical Therapy (PT) and Occupational Therapy (OT) Services | Added prior to 9/1/2019   |                         |
| G0158               | Services performed by a qualified occupational therapist assistant in the home health or hospice setting, each 15 minutes                                                                                          | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity, including condition being treated. | Home Health Hospice        | Illinois Medicaid Provider Manual, MCG, Medicare NCD/LCD Guidelines                 | PSY301.014 - Delete THE803.010 | Autism Spectrum Disorders (ASD) - Delete Physical Therapy (PT) and Occupational Therapy (OT) Services | Added prior to 9/1/2019   |                         |
| G0159               | Services performed by a qualified physical therapist, in the home health setting, in the establishment or delivery of a safe and effective physical therapy maintenance program, each 15 minutes                   | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity, including condition being treated. | Home Health Hospice        | Illinois Medicaid Provider Manual, MCG, Medicare NCD/LCD Guidelines                 | THE803.010                     | Physical Therapy (PT) and Occupational Therapy (OT) Services                                          | Added prior to 9/1/2019   |                         |
| G0160               | Services performed by a qualified occupational therapist, in the home health setting, in the establishment or delivery of a safe and effective occupational therapy maintenance program, each 15 minutes           | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity, including condition being treated. | Home Health Hospice        | Illinois Medicaid Provider Manual, MCG, Medicare NCD/LCD Guidelines                 | THE803.010                     | Physical Therapy (PT) and Occupational Therapy (OT) Services                                          | Added prior to 9/1/2019   |                         |
| G0161               | Services performed by a qualified speech-language pathologist, in the home health setting, in the establishment or delivery of a safe and effective speech-language pathology maintenance program, each 15 minutes | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity, including condition being treated. | Home Health Hospice        | Illinois Medicaid Provider Manual, MCG, Medicare NCD/LCD Guidelines                 | THE803.014                     | Speech-Language Therapy (SLT)                                                                         | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code                                                                                                                                                                                                                                   | Medical Records Request Information Required                                                                                                   | Clinical Criteria Category | Clinical Criteria Hierarchy                                                                                                     | Medical Policy Number | Medical Policy Name | Effective and Change Date | Date Posted to Website* |
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| G0219               | Pet imaging whole body; melanoma for non-covered indications                                                                                                                                                                                                    | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity, including condition being treated. | Radiology                  | BCBs Medical Policy, MCG, Medicare NCD/LCD Guidelines                                                                           | No Med Policy         | No medical policy   | Added prior to 9/1/2019   |                         |
| G0235               | Pet imaging, any site, not otherwise specified                                                                                                                                                                                                                  | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity, including condition being treated. | Radiology                  | BCBs Medical Policy, MCG, Medicare NCD/LCD Guidelines                                                                           | No Med Policy         | No medical policy   | Added prior to 9/1/2019   |                         |
| G0252               | Pet imaging, full and partial-ring PET scanners only, for initial diagnosis of breast cancer and/or surgical planning for breast cancer (e.g., initial staging of axillary lymph nodes)                                                                         | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity, including condition being treated. | Radiology                  | BCBs Medical Policy, MCG, Medicare NCD/LCD Guidelines                                                                           | No Med Policy         | No medical policy   | Added prior to 9/1/2019   |                         |
| G0260               | Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography                                                                                                                         | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                                 | Musculoskeletal            | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon             | Change 8/1/2025           |                         |
| G0281               | Electrical stimulation, (unattended), to one or more areas, for chronic stage iii and stage iv pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, a  | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                                 | Musculoskeletal            | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon             | Change 8/1/2025           |                         |
| G0282               | Electrical stimulation, (unattended), to one or more areas, for wound care other than described in G0281                                                                                                                                                        | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                                 | Musculoskeletal            | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon             | Change 8/1/2025           |                         |
| G0283               | Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care                                                                                                                            | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                                 | Musculoskeletal            | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon             | Change 8/1/2025           |                         |
| G0299               | Direct skilled nursing services of a registered nurse (rn) in the home health or hospice setting, each 15 minutes                                                                                                                                               | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity, including condition being treated. | Home Health Hospice        | Illinois Medicaid Provider Manual, MCG, Medicare NCD/LCD Guidelines                                                             | No Med Policy         | No medical policy   | Added prior to 9/1/2019   |                         |
| G0300               | Direct skilled nursing services of a license practical nurse (lpn) in the home health or hospice setting, each 15 minutes                                                                                                                                       | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity, including condition being treated. | Home Health Hospice        | Illinois Medicaid Provider Manual, MCG, Medicare NCD/LCD Guidelines                                                             | No Med Policy         | No medical policy   | Added prior to 9/1/2019   |                         |
| G0329               | Electromagnetic therapy, to one or more areas for chronic stage iii and stage iv pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care as part of a thera | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                                 | Musculoskeletal            | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon             | Change 8/1/2025           |                         |
| G0339               | ROBOT LIN-RADSURG COM, FIRST                                                                                                                                                                                                                                    | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                                 | Radiation Therapy          | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon             | Change 8/1/2025           |                         |
| G0340               | ROBOT LIN-RADSURG FRACTX 2-5                                                                                                                                                                                                                                    | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                                 | Radiation Therapy          | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon             | Change 8/1/2025           |                         |

| CPT and HCPCS Codes | Description of Procedure Code                                                                                                                                                  | Medical Records Request Information Required                                      | Clinical Criteria Category | Clinical Criteria Hierarchy                                                                                       | Medical Policy Number           | Medical Policy Name                                                             | Effective and Change Date | Date Posted to Website* |
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| G0398               | Home sleep study test (hst) with type ii portable monitor, unattended; minimum of 7 channels: eeg, eog, emg, ecg/heart rate, airflow, respiratory effort and oxygen saturation | Recent history and physical, plan of care, and documentation of medical necessity | Sleep                      | Illinois Medicaid Provider Manual, Illinois Administrative Code, BCBS Medical Policy, Medicare NCD/LCD Guidelines | MED204.005                      | Diagnosis of Obstructive Sleep Apnea Syndrome                                   | Added prior to 9/1/2019   |                         |
| G0399               | Home sleep test (hst) with type iii portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ecg/heart rate and 1 oxygen saturation              | Recent history and physical, plan of care, and documentation of medical necessity | Sleep                      | Illinois Medicaid Provider Manual, Illinois Administrative Code, BCBS Medical Policy, Medicare NCD/LCD Guidelines | MED204.005                      | Diagnosis of Obstructive Sleep Apnea Syndrome                                   | Added prior to 9/1/2019   |                         |
| G0400               | Home sleep test (hst) with type iv portable monitor, unattended; minimum of 3 channels                                                                                         | Recent history and physical, plan of care, and documentation of medical necessity | Sleep                      | Illinois Medicaid Provider Manual, Illinois Administrative Code, BCBS Medical Policy, Medicare NCD/LCD Guidelines | MED204.005                      | Diagnosis of Obstructive Sleep Apnea Syndrome                                   | Added prior to 9/1/2019   |                         |
| G6002               | STEREOSCOPIC X-RAY GUIDANCE                                                                                                                                                    | Carelon-https://providerportal.com/ or 866-455-8415                               | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/                                                          | Carelon                         | Carelon                                                                         | Change 8/1/2025           |                         |
| G6003               | Radiation Treatment Delivery, single area, up to 5 mev                                                                                                                         | Carelon-https://providerportal.com/ or 866-455-8415                               | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/                                                          | Carelon                         | Carelon                                                                         | Change 8/1/2025           |                         |
| G6004               | Radiation Treatment Delivery, single area, 6-10 mev                                                                                                                            | Carelon-https://providerportal.com/ or 866-455-8415                               | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/                                                          | Carelon                         | Carelon                                                                         | Change 8/1/2025           |                         |
| G6005               | Radiation Treatment Delivery, single area, 11-19 mev                                                                                                                           | Carelon-https://providerportal.com/ or 866-455-8415                               | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/                                                          | Carelon                         | Carelon                                                                         | Change 8/1/2025           |                         |
| G6006               | Radiation Treatment Delivery, single area, 20 mev or greater                                                                                                                   | Carelon-https://providerportal.com/ or 866-455-8415                               | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/                                                          | Carelon                         | Carelon                                                                         | Change 8/1/2025           |                         |
| G6007               | Radiation Treatment Delivery, 2 separate areas, up to 5 mev                                                                                                                    | Carelon-https://providerportal.com/ or 866-455-8415                               | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/                                                          | Carelon                         | Carelon                                                                         | Change 8/1/2025           |                         |
| G6008               | Radiation Treatment Delivery, 2 separate areas, area, 6-10 mev                                                                                                                 | Carelon-https://providerportal.com/ or 866-455-8415                               | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/                                                          | Carelon                         | Carelon                                                                         | Change 8/1/2025           |                         |
| G6009               | Radiation Treatment Delivery, 2 separate areas, 11-19 mev                                                                                                                      | Carelon-https://providerportal.com/ or 866-455-8415                               | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/                                                          | Carelon                         | Carelon                                                                         | Change 8/1/2025           |                         |
| G6010               | Radiation Treatment Delivery, 2 separate areas, 20 mev or greater                                                                                                              | Carelon-https://providerportal.com/ or 866-455-8415                               | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/                                                          | Carelon                         | Carelon                                                                         | Change 8/1/2025           |                         |
| G6011               | Radiation Treatment Delivery, 3 or more separate areas, up to 5 mev                                                                                                            | Carelon-https://providerportal.com/ or 866-455-8415                               | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/                                                          | Carelon                         | Carelon                                                                         | Change 8/1/2025           |                         |
| G6012               | Radiation Treatment Delivery, 3 or more separate areas, 6-10 mev                                                                                                               | Carelon-https://providerportal.com/ or 866-455-8415                               | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/                                                          | Carelon                         | Carelon                                                                         | Change 8/1/2025           |                         |
| G6013               | Radiation Treatment Delivery, 3 or more separate areas, 11-19 mev                                                                                                              | Carelon-https://providerportal.com/ or 866-455-8415                               | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/                                                          | Carelon                         | Carelon                                                                         | Change 8/1/2025           |                         |
| G6014               | Radiation Treatment Delivery, 3 or more separate areas, 20 mev or greater                                                                                                      | Carelon-https://providerportal.com/ or 866-455-8415                               | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/                                                          | Carelon                         | Carelon                                                                         | Change 8/1/2025           |                         |
| G6015               | Radiation Tx delivery imrt                                                                                                                                                     | Carelon-https://providerportal.com/ or 866-455-8415                               | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/                                                          | Carelon                         | Carelon                                                                         | Change 8/1/2025           |                         |
| G6016               | Delivery comp imrt                                                                                                                                                             | Carelon-https://providerportal.com/ or 866-455-8415                               | Radiation Therapy          | https://guidelines.carelonmedicalbenefitsmanagement.com/                                                          | Carelon                         | Carelon                                                                         | Change 8/1/2025           |                         |
| J0129               | Injection, abatacept, 10 mg (code may be used for medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered)     | SRU                                                                               | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                               | RX502.061 RX501.113 ADM1001.034 | Oncology Medications Abatacept Specialty Medication Administration Site of Care | Added prior to 9/1/2019   |                         |
| J0172               | Injection, aducanumab-avwa, 2 mg                                                                                                                                               | Letter of medical necessity, including condition being treated.                   | Medical Drug               | BCBS Medical Policy, MCG, Medicare NCD/LCD Guidelines                                                             | RX501.137                       | Aducanumab-Avwa                                                                 | added 7/1/2022            |                         |

| CPT and HCPCS Codes | Description of Procedure Code                                                   | Medical Records Request Information Required                                                                                                                                                                                                           | Clinical Criteria Category | Clinical Criteria Hierarchy                                                         | Medical Policy Number    | Medical Policy Name                                                                                            | Effective and Change Date | Date Posted to Website* |
|---------------------|---------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-------------------------------------------------------------------------------------|--------------------------|----------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------|
| J0174               | Leqembi (Injection, lecanemab-irmb, 1mg).                                       | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity                                                                                                                                             | Medical Drug               | BCBS Medical Policy, MCG, Medicare NCD/LCD Guidelines                               | RX501.152                | Lecanemab-irmb                                                                                                 | Added 7/1/2024            |                         |
| J0175               | Injection, donanemab-azbt, 2 mg                                                 | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity                                                                                                                                             | Medical Drug               | BCBS Medical Policy, MCG, Medicare NCD/LCD Guidelines                               | RX501.177                | Donanemab-azbt                                                                                                 | 4/1/2025                  |                         |
| J0177               | njection, aflibercept hd, 1 mg                                                  | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity                                                                                                                                             | Medical Drug               | BCBS Medical Policy, MCG, Medicare NCD/LCD Guidelines                               | OTH903.027               | Aflibercept                                                                                                    | 4/1/2024                  |                         |
| J0178               | Injection, aflibercept, 1 mg                                                    | Recent history and physical, plan of care, and documentation of medical necessity.                                                                                                                                                                     | Medical Drug               | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines  | OTH903.027               | <a href="#">Aflibercept and Associated Biosimilar(s)</a>                                                       | Change 11/1/2025          | 9/1/2025                |
| J0179               | Injection, brolucizumab-dbl, 1 mg                                               | Recent history and physical, plan of care, and documentation of medical necessity.                                                                                                                                                                     | Medical Drug               | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines  | OTH903.043               | <a href="#">Brolucizumab-dbl</a>                                                                               | Change 11/1/2025          | 9/1/2025                |
| J0180               | Injection, agalsidase beta, 1 mg                                                | SRU                                                                                                                                                                                                                                                    | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | RX501.067<br>ADM1001.034 | Enzyme-Replacement Therapy for Lysosomal Storage Disorders<br>Specialty Medication Administration Site of Care | Added prior to 9/1/2019   |                         |
| J0202               | Injection, alemtuzumab, 1 mg                                                    | SRU                                                                                                                                                                                                                                                    | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | RX501.077                | Alemtuzumab                                                                                                    | Added prior to 9/1/2019   |                         |
| J0217               | Injection, velmanase alfa-tycv, 1 mg                                            | Recent history and physical, plan of care, and documentation of medical necessity.                                                                                                                                                                     | Medical Drug               | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines  | No Med Policy            | No medical policy                                                                                              | Change 11/1/2025          | 9/1/2025                |
| J0218               | Injection, olipudase alfa-rpcp, 1 mg                                            | SRU                                                                                                                                                                                                                                                    | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | RX501.067<br>ADM1001.034 | Enzyme-Replacement Therapy for Lysosomal Storage Disorders<br>Specialty Medication Administration Site of Care | 4/1/2023                  |                         |
| J0219               | Injection, avalglucosidase alfa-ngpt, 4 mg                                      | SRU                                                                                                                                                                                                                                                    | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | RX501.067<br>ADM1001.034 | Enzyme-Replacement Therapy for Lysosomal Storage Disorders<br>Specialty Medication Administration Site of Care | 4/1/2022                  |                         |
| J0221               | Injection, alglucosidase alfa, (lumizyme), 10 mg                                | SRU                                                                                                                                                                                                                                                    | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | RX501.067<br>ADM1001.035 | Enzyme-Replacement Therapy for Lysosomal Storage Disorders                                                     | Added prior to 9/1/2019   |                         |
| J0223               | Givosiran                                                                       | SRU                                                                                                                                                                                                                                                    | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | RX501.125<br>ADM1001.034 | Givosiran<br>Specialty Medication Administration Site of Care                                                  | 1/1/2021                  |                         |
| J0224               | Inj. lumasiran, 0.5 mg                                                          | SRU                                                                                                                                                                                                                                                    | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | RX501.133<br>ADM1001.034 | Lumasiran<br>Medication Administration Site of Care                                                            | 7/1/2022                  |                         |
| J0225               | Injection, vutrisiran, 1 mg                                                     | SRU                                                                                                                                                                                                                                                    | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | RX501.146                | Vutrisiran                                                                                                     | 11/1/2022                 |                         |
| J0248               | Veklury (remdesivir)                                                            | Recent history and physical, plan of care, and documentation of medical necessity.                                                                                                                                                                     | Medical Drug               | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines  | RX501.130                | <a href="#">Remdesivir</a>                                                                                     | Change 11/1/2025          | 9/1/2025                |
| J0256               | Injection, alpha 1 proteinase inhibitor (human), not otherwise specified, 10 mg | Recent history and physical, plan of care, and documentation of medical necessity.                                                                                                                                                                     | Medical Drug               | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines  | No Med Policy            | No medical policy                                                                                              | Change 11/1/2025          | 9/1/2025                |
| J0257               | Injection, alpha 1 proteinase inhibitor (human), (glassia), 10 mg               | Recent history and physical, plan of care, and documentation of medical necessity.                                                                                                                                                                     | Medical Drug               | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines  | No Med Policy            | No medical policy                                                                                              | Change 11/1/2025          | 9/1/2025                |
| J0364               | Injection, apomorphine hydrochloride, 1 mg                                      | BCBSIL will review buy and bill drugs. Contact Prime Therapeutics, if billing pharmacy, (Fax 877-243-6930, Call 800-285-9426, visit MyPrime.com or CoverMyMeds.com) Recent history and physical, plan of care, and documentation of medical necessity. | Medical Drug               | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines  | No Med Policy            | No medical policy                                                                                              | Change 11/1/2025          | 9/1/2025                |
| J0490               | Injection, belimumab, 10 mg                                                     | SRU                                                                                                                                                                                                                                                    | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | RX501.116<br>ADM1001.034 | Belimumab<br>Medication Administration Site of Care                                                            | Added prior to 9/1/2019   |                         |
| J0491               | Injection, anifrolumab-fnia, 1 mg                                               | SRU                                                                                                                                                                                                                                                    | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | RX501.138<br>ADM1001.034 | Anifrolumab-fnia<br>Medication Administration Site of Care                                                     | 4/1/2022                  |                         |
| J0517               | Fasenra                                                                         | SRU                                                                                                                                                                                                                                                    | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | RX501.100<br>ADM1001.034 | Benralizumab<br>Medication Administration Site of Care                                                         | 1/1/2020                  |                         |

| CPT and HCPCS Codes | Description of Procedure Code                                                                                                                                           | Medical Records Request Information Required                                                                                                                                                                                                           | Clinical Criteria Category | Clinical Criteria Hierarchy                                                         | Medical Policy Number                  | Medical Policy Name                                                                                                                         | Effective and Change Date | Date Posted to Website* |
|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-------------------------------------------------------------------------------------|----------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------|
| J0565               | Zinplava 1000 MG/40ML SOLN J0565 Injection, bezlotoxumab, 10 mg                                                                                                         | Recent history and physical, plan of care, and documentation of medical necessity.                                                                                                                                                                     | Medical Drug               | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines  | No Med Policy                          | No medical policy                                                                                                                           | Change 11/1/2025          | 9/1/2025                |
| J0584               | Crysita                                                                                                                                                                 | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity                                                                                                                                             | Medical Drug               | BCBS Medical Policy, MCG, Medicare NCD/LCD Guidelines                               | RX502.058<br>AMD1001.034               | Burosumab-twza<br>Specialty<br>Medication Administration Site of Care                                                                       | Added 1/1/2025            |                         |
| J0585               | Injection, onabotulinumtoxin, 1 unit                                                                                                                                    | SRU                                                                                                                                                                                                                                                    | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | RX501.019<br>ADM1001.034<br>MED201.014 | Botulinum Toxin<br>Specialty Medication Administration Site of Care<br>Treatment of Hyperhidrosis                                           | Added prior to 9/1/2019   |                         |
| J0586               | Injection, abobotulinumtoxin, 5 units                                                                                                                                   | SRU                                                                                                                                                                                                                                                    | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | RX501.019<br>ADM1001.034<br>MED201.014 | Botulinum Toxin<br>Specialty Medication Administration Site of Care<br>Treatment of Hyperhidrosis                                           | Added prior to 9/1/2019   |                         |
| J0587               | Injection, rimabotulinumtoxinb, 100 units                                                                                                                               | SRU                                                                                                                                                                                                                                                    | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | RX501.019<br>ADM1001.034<br>MED201.014 | Botulinum Toxin<br>Specialty Medication Administration Site of Care<br>Treatment of Hyperhidrosis                                           | Added prior to 9/1/2019   |                         |
| J0588               | Injection, incobotulinumtoxin a, 1 unit                                                                                                                                 | SRU                                                                                                                                                                                                                                                    | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | RX501.019<br>ADM1001.034<br>MED201.014 | Botulinum Toxin<br>Specialty Medication Administration Site of Care<br>Treatment of Hyperhidrosis                                           | Added prior to 9/1/2019   |                         |
| J0589               | Injection, daxibotulinumtoxinalanm                                                                                                                                      | SRU                                                                                                                                                                                                                                                    | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | RX501.019                              | Botulinum Toxin                                                                                                                             | 4/1/2024                  |                         |
| J0596               | Injection, c1 esterase inhibitor (recombinant), ruconest, 10 units                                                                                                      | BCBSIL will review buy and bill drugs. Contact Prime Therapeutics, if billing pharmacy, (Fax 877-243-6930, Call 800-285-9426, visit MyPrime.com or CoverMyMeds.com) Recent history and physical, plan of care, and documentation of medical necessity. | Medical Drug               | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines  | No Med Policy                          | No medical policy                                                                                                                           | Change 11/1/2025          | 9/1/2025                |
| J0597               | Injection, c-1 esterase inhibitor (human), berinert, 10 units                                                                                                           | BCBSIL will review buy and bill drugs. Contact Prime Therapeutics, if billing pharmacy, (Fax 877-243-6930, Call 800-285-9426, visit MyPrime.com or CoverMyMeds.com) Recent history and physical, plan of care, and documentation of medical necessity. | Medical Drug               | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines  | No Med Policy                          | No medical policy                                                                                                                           | Change 11/1/2025          | 9/1/2025                |
| J0598               | Injection, c-1 esterase inhibitor (human), cinryze, 10 units                                                                                                            | SRU                                                                                                                                                                                                                                                    | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | RX504.013<br>ADM1001.034               | Management of Hereditary Angioedema (HAE) with C1 Esterase Inhibitor, Human Ecallantide<br>Specialty Medication Administration Site of Care | Added prior to 9/1/2019   |                         |
| J0606               | 5 MG/ML SOLN J0606 Injection, etelcalcetide, 0.1 mg and 2.5 MG/0.5ML SOLN J0606 Injection, etelcalcetide, 0.1 mg and 10 MG/2ML SOLN J0606 Injection, etelcalcetide, 0.1 | Recent history and physical, plan of care, and documentation of medical necessity.                                                                                                                                                                     | Medical Drug               | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines  | No Med Policy                          | No medical policy                                                                                                                           | Change 11/1/2025          | 9/1/2025                |
| J0638               | Injection, canakinumab, 1 mg                                                                                                                                            | SRU                                                                                                                                                                                                                                                    | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | RX501.119<br>ADM1001.034               | Canakinumab<br>Specialty<br>Medication Administration Site of Care                                                                          | Added prior to 9/1/2019   |                         |
| J0641               | Levoleucovorin Calcium                                                                                                                                                  | Carelon-https://providerportal.com/ or 866-455-8415                                                                                                                                                                                                    | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                            | Carelon                                | Carelon                                                                                                                                     | Change 8/1/2025           |                         |
| J0642               | Levoleucovorin                                                                                                                                                          | Carelon-https://providerportal.com/ or 866-455-8415                                                                                                                                                                                                    | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                            | Carelon                                | Carelon                                                                                                                                     | Change 8/1/2025           |                         |
| J0739               | Injection, cabotegravir 1 mg                                                                                                                                            | BCBSIL will review buy and bill drugs. Contact Prime Therapeutics, if billing pharmacy, (Fax 877-243-6930, Call 800-285-9426, visit MyPrime.com or CoverMyMeds.com) Recent history and physical, plan of care, and documentation of medical necessity. | Medical Drug               | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines  | No Med Policy                          | No medical policy                                                                                                                           | Change 11/1/2025          | 9/1/2025                |
| J0741               | Inj, cabote rilpivir 2mg 3mg                                                                                                                                            | SRU                                                                                                                                                                                                                                                    | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | RX501.145                              | Long-Acting Injectable Antiretroviral Agents for Treatment of HIV                                                                           | Added 10/1/2023           |                         |
| J0775               | Injection, collagenase, clostridium histolyticum, 0.01 mg                                                                                                               | SRU                                                                                                                                                                                                                                                    | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | RX501.073                              | Clostridial Collagenase for Fibroproliferative Disorders                                                                                    | Added prior to 9/1/2019   |                         |
| J0791               | Crizanlizumab-tmca (Adakveo)                                                                                                                                            | SRU                                                                                                                                                                                                                                                    | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | RX501.126<br>ADM1001.034               | Crizanlizumab-tmca<br>Specialty<br>Medication Administration Site of Care                                                                   | 1/1/2021                  |                         |
| J0800               | Injection, corticotropin, up to 40 units                                                                                                                                | Recent history and physical, plan of care, and documentation of medical necessity.                                                                                                                                                                     | Medical Drug               | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines  | No Med Policy                          | No medical policy                                                                                                                           | Change 11/1/2025          | 9/1/2025                |

| CPT and HCPCS Codes | Description of Procedure Code                            | Medical Records Request Information Required                                                                                                                                                                                                                                                 | Clinical Criteria Category | Clinical Criteria Hierarchy                                                                                                     | Medical Policy Number | Medical Policy Name                                                                                                                      | Effective and Change Date | Date Posted to Website* |
|---------------------|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|---------------------------------------------------------------------------------------------------------------------------------|-----------------------|------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------|
| J0881               | Injection, darbepoetin alfa, 1 microgram (for non-esrd)  | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 Carelon will review requests for oncology drugs that are supported by an oncology diagnosis. If the drug requested is not associated with an oncology diagnosis, it will be reviewed by BCBS. | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                                                                                                  | 10/1/2025                 | 9/1/2025                |
| J0881               | Injection, darbepoetin alfa, 1 microgram (for non-esrd)  | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity                                                                                                                                                                                   | Medical Drug               | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX502.061 RX501.069   | Oncology Medications Stimulating Agents (ESAs) Erythropoiesis-                                                                           | Added 1/1/2025            |                         |
| J0885               | Injection, epoetin alfa, (for non esrd use), 1000 units  | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 Carelon will review requests for oncology drugs that are supported by an oncology diagnosis. If the drug requested is not associated with an oncology diagnosis, it will be reviewed by BCBS. | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                                                                                                  | 10/1/2025                 | 9/1/2025                |
| J0885               | Injection, epoetin alfa, (for non esrd use), 1000 units  | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity                                                                                                                                                                                   | Medical Drug               | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX502.061 RX501.069   | Oncology Medications Stimulating Agents (ESAs) Erythropoiesis-                                                                           | Added 1/1/2025            |                         |
| J0888               | Injection, epoetin beta, 1 microgram, (for non esrd use) | SRU                                                                                                                                                                                                                                                                                          | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.069             | Erythropoiesis-Stimulating Agents (ESAs)                                                                                                 | Added prior to 9/1/2019   |                         |
| J0896               | Injection, luspatercept-aamt, 0.25 mg                    | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                                                                                                                                                                               | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                                                                                                  | Change 8/1/2025           |                         |
| J0897               | Injection, denosumab, 1 mg                               | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                                                                                                                                                                               | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                                                                                                  | Change 8/1/2025           |                         |
| J1203               | Injection, cipaglucosidase alfa-atga, 5 mg               | SRU                                                                                                                                                                                                                                                                                          | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.067             | Enzyme-Replacement Therapy for Lysosomal Storage Disorders                                                                               | 4/1/2024                  |                         |
| J1290               | Injection, ecallantide, 1 mg                             | SRU                                                                                                                                                                                                                                                                                          | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX504.013 ADM1001.034 | Management of Hereditary Angioedema (HAE) with C1 Esterase Inhibitor, Human Ecallantide Specialty Medication Administration Site of Care | Added prior to 9/1/2019   |                         |
| J1300               | Injection, eculizumab, 10 mg                             | SRU                                                                                                                                                                                                                                                                                          | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.066 ADM1001.034 | Eculizumab and Associated Biosimilar(s) Specialty Medication Administration Site of Care                                                 | Added prior to 9/1/2019   |                         |
| J1301               | Radicava                                                 | SRU                                                                                                                                                                                                                                                                                          | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.095 ADM1001.034 | Edaravone Specialty Medication Administration Site of Care                                                                               | 1/1/2020                  |                         |
| J1302               | Injection, sutimlimab-jome, 10 mg                        | SRU                                                                                                                                                                                                                                                                                          | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.087 ADM1001.034 | FDA-Approved Drugs, Biologicals, Cellular and Gene Therapies Specialty Medication Administration Site of Care                            | 10/1/2022                 |                         |
| J1303               | Ultomiris                                                | SRU                                                                                                                                                                                                                                                                                          | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.107 ADM1001.034 | Ravulizumab-cwvz Specialty Medication Administration Site of Care                                                                        | 10/1/2019                 |                         |
| J1304               | Injection, tofersen, 1 mg                                | SRU                                                                                                                                                                                                                                                                                          | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.162             | Tofersen                                                                                                                                 | 1/1/2024                  |                         |
| J1305               | Inj, evinacumab-dgnb, 5mg                                | SRU                                                                                                                                                                                                                                                                                          | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | ADM1001.034           | Specialty Medication Administration Site of Care                                                                                         | Added 10/1/2023           |                         |
| J1306               | Injection, inclisiran, 1 mg                              | SRU                                                                                                                                                                                                                                                                                          | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.142 ADM1001.034 | Inclisiran Specialty Medication Administration Site of Care                                                                              | Added 10/1/2023           |                         |
| J1322               | Injection, elosulfate alfa, 1 mg                         | SRU                                                                                                                                                                                                                                                                                          | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.067 ADM1001.034 | Enzyme-Replacement Therapy for Lysosomal Storage Disorders Specialty Medication Administration Site of Care                              | Added prior to 9/1/2019   |                         |
| J1323               | Eranatamab-bcmm                                          | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                                                                                                                                                                               | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                                                                                                  | Change 8/1/2025           |                         |
| J1325               | Injection, epoprostenol, 0.5 mg                          | BCBSIL will review buy and bill drugs. Contact Prime Therapeutics, if billing pharmacy, (Fax 877-243-6930, Call 800-285-9426, visit MyPrime.com or CoverMyMeds.com) Recent history and physical, plan of care, and documentation of medical necessity.                                       | Medical Drug               | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | RX501.056             | Advanced Therapies for Pharmacologic Treatment of Pulmonary Hypertension                                                                 | Change 11/1/2025          | 9/1/2025                |
| J1411               | Hemmens                                                  | Recent history and physical, plan of care, and documentation of medical necessity.                                                                                                                                                                                                           | Medical Drug               | BCBS Medical Policy, MCG, Medicare NCD/LCD Guidelines                                                                           | RX501.151             | Etranacogene dezaparvovec-drlb                                                                                                           | Added 7/1/2024            |                         |
| J1412               | Roctavian                                                | Recent history and physical, plan of care, and documentation of medical necessity.                                                                                                                                                                                                           | Medical Drug               | BCBS Medical Policy, MCG, Medicare NCD/LCD Guidelines                                                                           | RX501.128             | Valoctocogene Roxaparvovec-rvox                                                                                                          | Added 7/1/2024            |                         |
| J1413               | Elevidys                                                 | Recent history and physical, plan of care, and documentation of medical necessity.                                                                                                                                                                                                           | Medical Drug               | BCBS Medical Policy, MCG, Medicare NCD/LCD Guidelines                                                                           | RX501.163             | Delandistrogene moxeparvovec-rokl                                                                                                        | Added 7/1/2024            |                         |

| CPT and HCPCS Codes | Description of Procedure Code                                                                                         | Medical Records Request Information Required                                                                                                                                                                                                                                                 | Clinical Criteria Category | Clinical Criteria Hierarchy                                                                                                     | Medical Policy Number    | Medical Policy Name                                                                                            | Effective and Change Date | Date Posted to Website* |
|---------------------|-----------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|---------------------------------------------------------------------------------------------------------------------------------|--------------------------|----------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------|
| J1427               | Vilteqso                                                                                                              | SRU                                                                                                                                                                                                                                                                                          | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.129                | Viltolarsen                                                                                                    | Added 10/1/2021           |                         |
| J1428               | 500 MG/10ML SOLN J1428 Injection, eteplirsen, 10 mg and Exondys 51 100 MG/2ML SOLN J1428 Injection, eteplirsen, 10 mg | SRU                                                                                                                                                                                                                                                                                          | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.084                | Eteplirsen                                                                                                     | Added prior to 9/1/2019   |                         |
| J1429               | Golodirsen/Vyondys                                                                                                    | SRU                                                                                                                                                                                                                                                                                          | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.122                | Golodirsen                                                                                                     | 1/1/2021                  |                         |
| J1442               | Injection, filgrastim (g-CSF), excludes biosimilars, 1 microgram                                                      | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                                                                                                                                                                               | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                                        | Change 8/1/2025           |                         |
| J1447               | Tbo-Filgrastim                                                                                                        | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                                                                                                                                                                               | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                                        | Change 8/1/2025           |                         |
| J1448               | Trilaciclib Dihydrochloride                                                                                           | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                                                                                                                                                                               | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                                        | Change 8/1/2025           |                         |
| J1449               | Eflapegrastim-xnst                                                                                                    | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                                                                                                                                                                               | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                                        | Change 8/1/2025           |                         |
| J1458               | Injection, galsulfate, 1 mg                                                                                           | SRU                                                                                                                                                                                                                                                                                          | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.067<br>ADM1001.034 | Enzyme-Replacement Therapy for Lysosomal Storage Disorders<br>Specialty Medication Administration Site of Care | Added prior to 9/1/2019   |                         |
| J1459               | Injection, immune globulin (privigen), intravenous, non-lyophilized (e.g., liquid), 500 mg                            | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 Carelon will review requests for oncology drugs that are supported by an oncology diagnosis. If the drug requested is not associated with an oncology diagnosis, it will be reviewed by BCBS. | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                                        | 10/1/2025                 | 9/1/2025                |
| J1459               | Injection, immune globulin (privigen), intravenous, non-lyophilized (e.g., liquid), 500 mg                            | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity                                                                                                                                                                                   | Medical Drug               | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX504.003                | Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])                          | Added 11/1/2025           | 9/1/2025                |
| J1551               | Inj cutaqui 100 mg                                                                                                    | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 Carelon will review requests for oncology drugs that are supported by an oncology diagnosis. If the drug requested is not associated with an oncology diagnosis, it will be reviewed by BCBS. | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                                        | 10/1/2025                 | 9/1/2025                |
| J1551               | Inj cutaqui 100 mg                                                                                                    | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity                                                                                                                                                                                   | Medical Drug               | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX504.003                | Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])                          | Added 11/1/2025           | 9/1/2025                |
| J1554               | Asceniv                                                                                                               | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 Carelon will review requests for oncology drugs that are supported by an oncology diagnosis. If the drug requested is not associated with an oncology diagnosis, it will be reviewed by BCBS. | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                                        | 10/1/2025                 | 9/1/2025                |
| J1554               | Asceniv                                                                                                               | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity                                                                                                                                                                                   | Medical Drug               | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX504.003                | Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])                          | Added 11/1/2025           | 9/1/2025                |
| J1555               | Injection, immune globulin, 100 mg                                                                                    | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 Carelon will review requests for oncology drugs that are supported by an oncology diagnosis. If the drug requested is not associated with an oncology diagnosis, it will be reviewed by BCBS. | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                                        | 10/1/2025                 | 9/1/2025                |
| J1555               | Injection, immune globulin, 100 mg                                                                                    | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity                                                                                                                                                                                   | Medical Drug               | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX504.003                | Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])                          | Added 11/1/2025           | 9/1/2025                |
| J1556               | Injection, immune globulin (bivigam), 500 mg                                                                          | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 Carelon will review requests for oncology drugs that are supported by an oncology diagnosis. If the drug requested is not associated with an oncology diagnosis, it will be reviewed by BCBS. | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                                        | 10/1/2025                 | 9/1/2025                |
| J1556               | Injection, immune globulin (bivigam), 500 mg                                                                          | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity                                                                                                                                                                                   | Medical Drug               | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX504.003                | Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])                          | Added 11/1/2025           | 9/1/2025                |
| J1557               | Injection, immune globulin, (gammaglobulin), intravenous, non-lyophilized (e.g., liquid), 500 mg                      | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 Carelon will review requests for oncology drugs that are supported by an oncology diagnosis. If the drug requested is not associated with an oncology diagnosis, it will be reviewed by BCBS. | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                                        | 10/1/2025                 | 9/1/2025                |

| CPT and HCPCS Codes | Description of Procedure Code                                                                                | Medical Records Request Information Required                                                                                                                                                                                                                                                 | Clinical Criteria Category | Clinical Criteria Hierarchy                                                                                                     | Medical Policy Number | Medical Policy Name                                                                   | Effective and Change Date | Date Posted to Website* |
|---------------------|--------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|---------------------------------------------------------------------------------------------------------------------------------|-----------------------|---------------------------------------------------------------------------------------|---------------------------|-------------------------|
| J1557               | Injection, immune globulin, (gammaleX), intravenous, non-lyophilized (e.g., liquid), 500 mg                  | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity                                                                                                                                                                                   | Medical Drug               | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX504.003             | Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) | Added 11/1/2025           | 9/1/2025                |
| J1558               | Inj. xembify, 100 mg                                                                                         | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 Carelon will review requests for oncology drugs that are supported by an oncology diagnosis. If the drug requested is not associated with an oncology diagnosis, it will be reviewed by BCBS. | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                                               | 10/1/2025                 | 9/1/2025                |
| J1558               | Inj. xembify, 100 mg                                                                                         | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity                                                                                                                                                                                   | Medical Drug               | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX504.003             | Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) | Added 11/1/2025           | 9/1/2025                |
| J1559               | Injection, immune globulin (hizentra), 100 mg                                                                | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 Carelon will review requests for oncology drugs that are supported by an oncology diagnosis. If the drug requested is not associated with an oncology diagnosis, it will be reviewed by BCBS. | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                                               | 10/1/2025                 | 9/1/2025                |
| J1559               | Injection, immune globulin (hizentra), 100 mg                                                                | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity                                                                                                                                                                                   | Medical Drug               | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX504.003             | Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) | Added 11/1/2025           | 9/1/2025                |
| J1561               | Injection, immune globulin, (gamunex-c/gammaked), non-lyophilized (e.g., liquid), 500 mg                     | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 Carelon will review requests for oncology drugs that are supported by an oncology diagnosis. If the drug requested is not associated with an oncology diagnosis, it will be reviewed by BCBS. | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                                               | 10/1/2025                 | 9/1/2025                |
| J1561               | Injection, immune globulin, (gamunex-c/gammaked), non-lyophilized (e.g., liquid), 500 mg                     | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity                                                                                                                                                                                   | Medical Drug               | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX504.003             | Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) | Added 11/1/2025           | 9/1/2025                |
| J1566               | Injection, immune globulin, intravenous, lyophilized (e.g., powder), not otherwise specified, 500 mg         | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 Carelon will review requests for oncology drugs that are supported by an oncology diagnosis. If the drug requested is not associated with an oncology diagnosis, it will be reviewed by BCBS. | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                                               | 10/1/2025                 | 9/1/2025                |
| J1566               | Injection, immune globulin, intravenous, lyophilized (e.g., powder), not otherwise specified, 500 mg         | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity                                                                                                                                                                                   | Medical Drug               | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX504.003             | Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) | Added 11/1/2025           | 9/1/2025                |
| J1568               | Injection, immune globulin, (octagam), intravenous, non-lyophilized (e.g., liquid), 500 mg                   | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 Carelon will review requests for oncology drugs that are supported by an oncology diagnosis. If the drug requested is not associated with an oncology diagnosis, it will be reviewed by BCBS. | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                                               | 10/1/2025                 | 9/1/2025                |
| J1568               | Injection, immune globulin, (octagam), intravenous, non-lyophilized (e.g., liquid), 500 mg                   | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity                                                                                                                                                                                   | Medical Drug               | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX504.003             | Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) | Added 11/1/2025           | 9/1/2025                |
| J1569               | Injection, immune globulin, (gammagard liquid), non-lyophilized, (e.g., liquid), 500 mg                      | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 Carelon will review requests for oncology drugs that are supported by an oncology diagnosis. If the drug requested is not associated with an oncology diagnosis, it will be reviewed by BCBS. | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                                               | 10/1/2025                 | 9/1/2025                |
| J1569               | Injection, immune globulin, (gammagard liquid), non-lyophilized, (e.g., liquid), 500 mg                      | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity                                                                                                                                                                                   | Medical Drug               | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX504.003             | Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) | Added 11/1/2025           | 9/1/2025                |
| J1572               | Injection, immune globulin, (flebogamma/flebogamma dif), intravenous, non-lyophilized (e.g., liquid), 500 mg | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 Carelon will review requests for oncology drugs that are supported by an oncology diagnosis. If the drug requested is not associated with an oncology diagnosis, it will be reviewed by BCBS. | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                                               | 10/1/2025                 | 9/1/2025                |
| J1572               | Injection, immune globulin, (flebogamma/flebogamma dif), intravenous, non-lyophilized (e.g., liquid), 500 mg | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity                                                                                                                                                                                   | Medical Drug               | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX504.003             | Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) | Added 11/1/2025           | 9/1/2025                |
| J1575               | Injection, immune globulin/hyaluronidase, (hyqvia), 100 mg immunoglobulin                                    | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 Carelon will review requests for oncology drugs that are supported by an oncology diagnosis. If the drug requested is not associated with an oncology diagnosis, it will be reviewed by BCBS. | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                                               | 10/1/2025                 | 9/1/2025                |

| CPT and HCPCS Codes | Description of Procedure Code                                              | Medical Records Request Information Required                                                                                                                                                                                                                                                 | Clinical Criteria Category | Clinical Criteria Hierarchy                                                                                                     | Medical Policy Number    | Medical Policy Name                                                                             | Effective and Change Date | Date Posted to Website* |
|---------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|---------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------------------------------------------------------------------|---------------------------|-------------------------|
| J1575               | Injection, immune globulin/hyaluronidase, (hyqvia), 100 mg immune globulin | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity                                                                                                                                                                                   | Medical Drug               | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX504.003                | Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])           | Added 11/1/2025           | 9/1/2025                |
| J1576               | Immune Globulin (Human)-ifas                                               | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 Carelon will review requests for oncology drugs that are supported by an oncology diagnosis. If the drug requested is not associated with an oncology diagnosis, it will be reviewed by BCBS. | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                         | 10/1/2025                 | 9/1/2025                |
| J1576               | Immune Globulin (Human)-ifas                                               | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity                                                                                                                                                                                   | Medical Drug               | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX504.003                | Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])           | Added 11/1/2025           | 9/1/2025                |
| J1599               | Immune deficiency                                                          | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 Carelon will review requests for oncology drugs that are supported by an oncology diagnosis. If the drug requested is not associated with an oncology diagnosis, it will be reviewed by BCBS. | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                         | 10/1/2025                 | 9/1/2025                |
| J1599               | Immune deficiency                                                          | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity                                                                                                                                                                                   | Medical Drug               | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX504.003                | Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])           | Added 11/1/2025           | 9/1/2025                |
| J1602               | Injection, golimumab, 1 mg, for intravenous use                            | SRU                                                                                                                                                                                                                                                                                          | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.112<br>ADM1001.034 | Golimumab<br>Medication Administration Site of Care                                             | Added prior to 9/1/2019   |                         |
| J1632               | Brexanolone                                                                | Recent history and physical, plan of care, and documentation of medical necessity.                                                                                                                                                                                                           | Medical Drug               | BCBS Medical Policy, MCG, Medicare NCD/LCD Guidelines                                                                           | No Med Policy            | No medical policy                                                                               | 1/1/2020                  |                         |
| J1743               | Injection, idursulfase, 1 mg                                               | SRU                                                                                                                                                                                                                                                                                          | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.067<br>ADM1001.034 | Enzyme-Replacement Therapy for Lysosomal Storage Disorders<br>Specialty Medication Site of Care | Added prior to 9/1/2019   |                         |
| J1745               | Injection infliximab, 10 mg                                                | SRU                                                                                                                                                                                                                                                                                          | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.051<br>ADM1001.034 | Infliximab and Associated Biosimilars<br>Administration Site of Care<br>Acne Management         | Added prior to 9/1/2019   |                         |
| J1746               | Trogarzo                                                                   | SRU                                                                                                                                                                                                                                                                                          | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.099<br>ADM1001.034 | Ibalizumab-uiyk<br>Medication Administration Site of Care                                       | 1/1/2020                  |                         |
| J1786               | Injection, imiglucerase, 10 units                                          | SRU                                                                                                                                                                                                                                                                                          | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.067<br>ADM1001.034 | Enzyme-Replacement Therapy for Lysosomal Storage Disorders<br>Specialty Medication Site of Care | Added prior to 9/1/2019   |                         |
| J1823               | Uplizna                                                                    | SRU                                                                                                                                                                                                                                                                                          | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.127<br>ADM1001.034 | Inebilizumab-cdon<br>Medication Administration Site of Care                                     | 10/1/2021                 |                         |
| J1930               | Injection, lanreotide, 1 mg                                                | History and physical, chart notes from ordering physician, treatment plan including condition being treated.                                                                                                                                                                                 | Medical Drug               | BCBS Medical Policy, MCG, Medicare NCD/LCD Guidelines                                                                           | RX501.155                | Lanreotide                                                                                      | Added 1/1/2025            |                         |
| J1931               | Injection, laronidase, 0.1 mg                                              | SRU                                                                                                                                                                                                                                                                                          | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.067<br>ADM1001.034 | Enzyme-Replacement Therapy for Lysosomal Storage Disorders<br>Specialty Medication Site of Care | Added prior to 9/1/2019   |                         |
| J1932               | Injection, lanreotide, (ciplia), 1 mg                                      | History and physical, chart notes from ordering physician, treatment plan including condition being treated.                                                                                                                                                                                 | Medical Drug               | BCBS Medical Policy, MCG, Medicare NCD/LCD Guidelines                                                                           | MCG ACG: A-0574 (AC)     | Lanreotide ACG: A-0574                                                                          | Added 1/1/2025            |                         |
| J1950               | Injection, leuprolide acetate (for depot suspension), per 3.75 mg          | History and physical, chart notes from ordering physician, treatment plan including condition being treated.                                                                                                                                                                                 | Medical Drug               | BCBS Medical Policy, MCG, Medicare NCD/LCD Guidelines                                                                           | RX502.061<br>RX501.041   | Oncology Medications<br>Gonadotropin-Releasing Hormone (GnRH) Agonists and Antagonists          | Added 1/1/2025            |                         |
| J1951               | Injection, leuprolide acetate                                              | BCBSIL will review buy and bill drugs. Contact Prime Therapeutics, if billing pharmacy, (Fax 877-243-6930, Call 800-285-9426, visit MyPrime.com or CoverMyMeds.com) Recent history and physical, plan of care, and documentation of medical necessity.                                       | Medical Drug               | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | RX501.041                | Gonadotropin-Releasing Hormone (GnRH) Agonists and Antagonists                                  | Change 11/1/2025          | 9/1/2025                |
| J1961               | Injection, lenacapavir, 1 mg                                               | SRU                                                                                                                                                                                                                                                                                          | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.145                | Long-Acting Injectable Antiretroviral Agents for Treatment of HIV                               | 6/1/2023                  |                         |
| J2182               | 100 MG SOLR J2182 Injection, mepolizumab, 1 mg                             | SRU                                                                                                                                                                                                                                                                                          | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.080<br>ADM1001.034 | Mepolizumab<br>Medication Administration Site of Care                                           | Added prior to 9/1/2019   |                         |
| J2323               | Injection, natalizumab, 1 mg                                               | SRU                                                                                                                                                                                                                                                                                          | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.059<br>ADM1001.034 | Natalizumab and Associated Biosimilars<br>Administration Site of Care                           | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code                                                                                             | Medical Records Request Information Required                                                                                                                                                                                                           | Clinical Criteria Category | Clinical Criteria Hierarchy                                                                                                     | Medical Policy Number    | Medical Policy Name                                                                                   | Effective and Change Date | Date Posted to Website* |
|---------------------|---------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|---------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------------------------------------------------------------------------|---------------------------|-------------------------|
| J2326               | Injection, nusinersen, 0.1 mg                                                                                             | SRU                                                                                                                                                                                                                                                    | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.086                | Nusinersen                                                                                            | Added prior to 9/1/2019   |                         |
| J2327               | Inj risankizumab-rzaa 1 mg                                                                                                | SRU                                                                                                                                                                                                                                                    | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.147                | Risankizumab-rzaa                                                                                     | Added 10/1/2023           |                         |
| J2329               | Injection, ublituximab-xiiy, 1mg                                                                                          | SRU                                                                                                                                                                                                                                                    | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.153                | Ublituximab-xiiy                                                                                      | 7/1/2023                  |                         |
| J2350               | 300 MG/10ML SOLN J2350 Injection, ocrelizumab, 1 mg. New code effective 1/1/18 previously coded J3590 Go live was 11/1/17 | SRU                                                                                                                                                                                                                                                    | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.085<br>ADM1001.034 | Ocrelizumab or Ocrelizumab and Hyaluronidase-ocsq<br>Specialty Medication Administration Site of Care | Added prior to 9/1/2019   |                         |
| J2353               | Injection, octreotide, depot form for intramuscular injection, 1 mg                                                       | History and physical, chart notes from ordering physician, treatment plan including condition being treated.                                                                                                                                           | Medical Drug               | BCBS Medical Policy, MCG, Medicare NCD/LCD Guidelines                                                                           | RX501.156                | Octreotide                                                                                            | Added 1/1/2025            |                         |
| J2354               | Injection, octreotide, non-depot form for subcutaneous or intravenous injection, 25 mcg                                   | History and physical, chart notes from ordering physician, treatment plan including condition being treated.                                                                                                                                           | Medical Drug               | BCBS Medical Policy, MCG, Medicare NCD/LCD Guidelines                                                                           | RX501.156                | Octreotide                                                                                            | Added 1/1/2025            |                         |
| J2356               | Inj tezepelumab-ekko, 1mg                                                                                                 | SRU                                                                                                                                                                                                                                                    | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.143<br>ADM1001.034 | Tezepelumab-ekko<br>Specialty Medication Administration Site of Care                                  | Added 10/1/2023           |                         |
| J2357               | Injection, omalizumab, 5 mg                                                                                               | SRU                                                                                                                                                                                                                                                    | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.058<br>ADM1001.034 | Omalizumab<br>Specialty Medication Administration Site of Care                                        | Added prior to 9/1/2019   |                         |
| J2502               | Injection, pasireotide long acting, 1 mg                                                                                  | BCBSIL will review buy and bill drugs. Contact Prime Therapeutics, if billing pharmacy, (Fax 877-243-6930, Call 800-285-9426, visit MyPrime.com or CoverMyMeds.com) Recent history and physical, plan of care, and documentation of medical necessity. | Medical Drug               | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | RX501.079                | Pasireotide                                                                                           | Change 11/1/2025          | 9/1/2025                |
| J2506               | Injection, pegfilgrastim, excludes biosimilar, 0.5 mg                                                                     | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                                                                                                                                         | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                               | Change 8/1/2025           |                         |
| J2507               | Injection, pegloticase, 1 mg                                                                                              | SRU                                                                                                                                                                                                                                                    | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.120<br>ADM1001.034 | Pegloticase<br>Specialty Medication Administration Site of Care                                       | Added prior to 9/1/2019   |                         |
| J2508               | Pegunigalsidase alfa-iwxj, 1 mg                                                                                           | SRU                                                                                                                                                                                                                                                    | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.067                | Enzyme-Replacement Therapy for Lysosomal Storage Disorders                                            | 1/1/2024                  |                         |
| J2778               | Injection, ranibizumab, 0.1 mg                                                                                            | Recent history and physical, plan of care, and documentation of medical necessity.                                                                                                                                                                     | Medical Drug               | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | No Med Policy            | <a href="#">Ranibizumab Injections, Implants and Biosimilars</a>                                      | Change 11/1/2025          | 9/1/2025                |
| J2779               | Injection, ranibizumab via intravitreal implant (susvimo), 0.1 mg                                                         | Recent history and physical, plan of care, and documentation of medical necessity.                                                                                                                                                                     | Medical Drug               | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | OTH903.041               | <a href="#">Ranibizumab Injections, Implants and Biosimilars</a>                                      | Change 11/1/2025          | 9/1/2025                |
| J2781               | Injection, pegcetacoplan, intravitreal, 1 mg                                                                              | Recent history and physical, plan of care, and documentation of medical necessity.                                                                                                                                                                     | Medical Drug               | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | No Med Policy            | No medical policy                                                                                     | Change 11/1/2025          | 9/1/2025                |
| J2782               | Injection, avacincaptad pegol, 0.1 mg                                                                                     | Recent history and physical, plan of care, and documentation of medical necessity.                                                                                                                                                                     | Medical Drug               | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | OTH903.045               | <a href="#">Avacincaptad pegol</a>                                                                    | Change 11/1/2025          | 9/1/2025                |
| J2786               | 100 MG/10ML SOLN J2786 Injection, reslizumab, 1 mg                                                                        | SRU                                                                                                                                                                                                                                                    | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.083<br>ADM1001.034 | Reslizumab<br>Specialty Medication Administration Site of Care                                        | Added prior to 9/1/2019   |                         |
| J2793               | Injection, rilonacept, 1 mg                                                                                               | Recent history and physical, plan of care, and documentation of medical necessity.                                                                                                                                                                     | Medical Drug               | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | No Med Policy            | No medical policy                                                                                     | Change 11/1/2025          | 9/1/2025                |
| J2796               | Injection, romiplostim, 10 micrograms                                                                                     | History and physical, chart notes from ordering physician, treatment plan including condition being treated.                                                                                                                                           | Medical Drug               | BCBS Medical Policy, MCG, Medicare NCD/LCD Guidelines                                                                           | RX501.157                | Romiplostim                                                                                           | Added 1/1/2025            |                         |
| J2820               | Sargramostim                                                                                                              | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                                                                                                                                         | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                               | Change 8/1/2025           |                         |

| CPT and HCPCS Codes | Description of Procedure Code                                                                                                                              | Medical Records Request Information Required                                                                                                                                                                                                           | Clinical Criteria Category | Clinical Criteria Hierarchy                                                                                                     | Medical Policy Number | Medical Policy Name                                                                          | Effective and Change Date | Date Posted to Website* |
|---------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|---------------------------------------------------------------------------------------------------------------------------------|-----------------------|----------------------------------------------------------------------------------------------|---------------------------|-------------------------|
| J2840               | Kanuma 20 MG/10ML SOLN J2840 Injection, sebelipase alfa, 1 mg                                                                                              | History and physical, chart notes from ordering physician, treatment plan including condition being treated.                                                                                                                                           | Medical Drug               | BCBS Medical Policy, MCG, Medicare NCD/LCD Guidelines                                                                           | RX501.067 ADM1001.037 | Enzyme-Replacement Therapy for Lysosomal Storage Disorders Specialty Medication Site of Care | Added prior to 9/1/2019   |                         |
| J2860               | Siltuximab                                                                                                                                                 | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                                                                                                                                         | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                                                      | Change 8/1/2025           |                         |
| J2998               | Inj plasminogen tvmh 1mg                                                                                                                                   | Recent history and physical, plan of care, and documentation of medical necessity.                                                                                                                                                                     | Medical Drug               | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | No Med Policy         | No medical policy                                                                            | Change 11/1/2025          | 9/1/2025                |
| J3032               | Eptinezumab-jjmr (Vyepti)                                                                                                                                  | SRU                                                                                                                                                                                                                                                    | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.124 ADM1001.034 | Eptinezumab-jjmr Specialty Medication Administration Site of Care                            | 1/1/2021                  |                         |
| J3055               | Talquetamab-tgvs                                                                                                                                           | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                                                                                                                                         | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                                                      | Change 8/1/2025           |                         |
| J3060               | Injection, taliglucerase alfa, 10 units                                                                                                                    | SRU                                                                                                                                                                                                                                                    | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.067 ADM1001.034 | Enzyme-Replacement Therapy for Lysosomal Storage Disorders Specialty Medication Site of Care | Added prior to 9/1/2019   |                         |
| J3111               | Inj, romosozumab-aqqg, 1mg                                                                                                                                 | SRU                                                                                                                                                                                                                                                    | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.159 ADM1001.034 | Romosozumab-aqqg Specialty Medication Administration Site of Care                            | 1/1/2021                  |                         |
| J3241               | Teprotumumab-trbw                                                                                                                                          | SRU                                                                                                                                                                                                                                                    | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.110 ADM1001.034 | Teprotumumab Specialty Medication Administration Site of Care                                | 1/1/2021                  |                         |
| J3245               | Ilumya                                                                                                                                                     | SRU                                                                                                                                                                                                                                                    | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.123 ADM1001.034 | Tildrakizumab-asmn Specialty Medication Administration Site of Care                          | 1/1/2020                  |                         |
| J3262               | Injection, tocilizumab, 1 mg                                                                                                                               | History and physical, chart notes from ordering physician, treatment plan including condition being treated.                                                                                                                                           | Medical Drug               | BCBS Medical Policy, MCG, Medicare NCD/LCD Guidelines                                                                           | RX502.061 RX501.115   | Oncology Medications Tocilizumab and Associated Biosimilar(s)                                | Added 1/1/2025            |                         |
| J3263               | Toripalimab-tpzi                                                                                                                                           | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                                                                                                                                         | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                                                      | Change 8/1/2025           |                         |
| J3285               | Injection, trestatinil, 1 mg                                                                                                                               | BCBSIL will review buy and bill drugs. Contact Prime Therapeutics, if billing pharmacy, (Fax 877-243-6930, Call 800-285-9426, visit MyPrime.com or CoverMyMeds.com) Recent history and physical, plan of care, and documentation of medical necessity. | Medical Drug               | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | RX501.056             | Advanced Therapies for Pharmacologic Treatment of Pulmonary Hypertension                     | Change 11/1/2025          | 9/1/2025                |
| J3304               | Zilretta                                                                                                                                                   | Recent history and physical, plan of care, and documentation of medical necessity.                                                                                                                                                                     | Medical Drug               | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | No Med Policy         | No medical policy                                                                            | Change 11/1/2025          | 9/1/2025                |
| J3316               | Triptodur                                                                                                                                                  | Recent history and physical, plan of care, and documentation of medical necessity.                                                                                                                                                                     | Medical Drug               | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | RX501.041             | <a href="#">Gonadotropin-Releasing Hormone (GnRH) Agonists and Antagonists</a>               | Change 11/1/2025          | 9/1/2025                |
| J3357               | Stelara 45 MG/0.5ML SOLN J3357 Ustekinumab, for subcutaneous injection, 1 mg and Stelara 90 MG/ML SOSY J3357 Ustekinumab, for subcutaneous injection, 1 mg | BCBSIL will review buy and bill drugs. Contact Prime Therapeutics, if billing pharmacy, (Fax 877-243-6930, Call 800-285-9426, visit MyPrime.com or CoverMyMeds.com) Recent history and physical, plan of care, and documentation of medical necessity. | Medical Drug               | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | RX501.114             | Ustekinumab and Associated Biosimilars                                                       | Change 11/1/2025          | 9/1/2025                |
| J3358               | Stelara 130 MG/26ML SOLN J3358 Ustekinumab, for intravenous injection, 1 mg                                                                                | SRU                                                                                                                                                                                                                                                    | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.114 ADM1001.034 | Ustekinumab and Associated Biosimilars Specialty Medication Administration Site of Care      | Added prior to 9/1/2019   |                         |
| J3380               | Injection, vedolizumab, 1 mg                                                                                                                               | SRU                                                                                                                                                                                                                                                    | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.117 ADM1001.034 | Vedolizumab Specialty Medication Administration Site of Care                                 | Added prior to 9/1/2019   |                         |
| J3385               | Injection, velaglucerase alfa, 100 units                                                                                                                   | SRU                                                                                                                                                                                                                                                    | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.067 ADM1001.034 | Enzyme-Replacement Therapy for Lysosomal Storage Disorders Specialty Medication Site of Care | Added prior to 9/1/2019   |                         |
| J3392               | Inj. Exagamglogene autoem                                                                                                                                  | History and physical, chart notes from ordering physician, treatment plan including condition being treated.                                                                                                                                           | Medical Drug               | BCBS Medical Policy, MCG, Medicare NCD/LCD Guidelines                                                                           | RX501.166             | Exagamglogene autoemcel                                                                      | 7/1/2025                  |                         |
| J3393               | Inj. Betibeglogene                                                                                                                                         | History and physical, chart notes from ordering physician, treatment plan including condition being treated.                                                                                                                                           | Medical Drug               | BCBS Medical Policy, MCG, Medicare NCD/LCD Guidelines                                                                           | RX501.148 RX501.071   | Betibeglogene autotemcel Plerixafor for Non-Oncologic Indications                            | 7/1/2025                  |                         |
| J3394               | Inj. Lovotibeglogene autotem                                                                                                                               | History and physical, chart notes from ordering physician, treatment plan including condition being treated.                                                                                                                                           | Medical Drug               | BCBS Medical Policy, MCG, Medicare NCD/LCD Guidelines                                                                           | RX501.167 RX501.071   | Lovotibeglogene autotemcel Plerixafor for Non-oncologic Indications                          | 7/1/2025                  |                         |

| CPT and HCPCS Codes | Description of Procedure Code                                                                       | Medical Records Request Information Required                                                                                                                                                                                                                                                                                  | Clinical Criteria Category | Clinical Criteria Hierarchy                                                                                                     | Medical Policy Number    | Medical Policy Name                                                                             | Effective and Change Date | Date Posted to Website* |
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| J3397               | Mepsevii                                                                                            | SRU                                                                                                                                                                                                                                                                                                                           | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.067<br>ADM1001.034 | Enzyme-Replacement Therapy for Lysosomal Storage Disorders<br>Specialty Medication Site of Care | 1/1/2020                  |                         |
| J3398               | Luxturna                                                                                            | SRU                                                                                                                                                                                                                                                                                                                           | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.098                | Gene Therapy for Inherited Retinal Dystrophy                                                    | 1/1/2020                  |                         |
| J3399               | Zolgensma                                                                                           | SRU                                                                                                                                                                                                                                                                                                                           | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.104                | Onasemnogene Apeparvovec-xioi                                                                   | 1/1/2020                  |                         |
| J3490               | Unclassified drugs Non-Oncology                                                                     | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                                                                                                                                                                                                                | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                         | Change 8/1/2025           |                         |
| J3580               | Tzield                                                                                              | History and physical, chart notes from ordering physician, treatment plan including condition being treated.                                                                                                                                                                                                                  | Medical Drug               | BCBS Medical Policy, MCG, Medicare NCD/LCD Guidelines                                                                           | No Med Policy            | No medical policy                                                                               | Added 7/1/2023            |                         |
| J3590               | Unclassified biologics Non Oncology                                                                 | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 Carelon will review requests for oncology drugs that are supported by an oncology diagnosis. If the drug requested is not associated with an oncology diagnosis, it will be reviewed by BCBS.                                  | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                         | 10/1/2025                 | 9/1/2025                |
| J3590               | Unclassified biologics Non Oncology                                                                 | History and physical, chart notes from ordering physician, treatment plan including condition being treated.                                                                                                                                                                                                                  | Medical Drug               | BCBS Medical Policy, MCG, Medicare NCD/LCD Guidelines                                                                           | RX502.061                | <a href="#">Oncology Medications</a>                                                            | Added 11/1/2025           | 9/1/2025                |
| J7203               | Injection factor ix, (antihemophilic factor, recombinant), glycopegylated, (rebinyon), 1 iu         | BCBSIL will review buy and bill drugs. Contact Prime Therapeutics, if billing pharmacy, (Fax 877-243-6930, Call 800-285-9426, visit <a href="http://MyPrime.com">MyPrime.com</a> or <a href="http://CoverMyMeds.com">CoverMyMeds.com</a> ) Recent history and physical, plan of care, and documentation of medical necessity. | Medical Drug               | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | No Med Policy            | No medical policy                                                                               | Change 11/1/2025          | 9/1/2025                |
| J7214               | Injection, factor viii/von willebrand factor complex, recombinant (altuviiro), per factor viii i.u. | Recent history and physical, plan of care, and documentation of medical necessity.                                                                                                                                                                                                                                            | Medical Drug               | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | No Med Policy            | No medical policy                                                                               | Change 11/1/2025          | 9/1/2025                |
| J7318               | Durolane                                                                                            | Recent history and physical, plan of care, and documentation of medical necessity.                                                                                                                                                                                                                                            | Medical Drug               | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | RX501.049                | <a href="#">Viscosupplementation for Osteoarthritis</a>                                         | Change 11/1/2025          | 9/1/2025                |
| J7320               | Hyaluronan or derivative, genvisc 850, for intra-articular injection, 1 mg                          | History and physical, chart notes from ordering physician, treatment plan including condition being treated.                                                                                                                                                                                                                  | Medical Drug               | BCBS Medical Policy, MCG, Medicare NCD/LCD Guidelines                                                                           | RX501.049                | Viscosupplementation for Osteoarthritis                                                         | 1/1/2020                  |                         |
| J7321               | Hyaluronan or derivative, hyalgan or supartz, for intra-articular injection, per dose               | History and physical, chart notes from ordering physician, treatment plan including condition being treated.                                                                                                                                                                                                                  | Medical Drug               | BCBS Medical Policy, MCG, Medicare NCD/LCD Guidelines                                                                           | RX501.049                | Viscosupplementation for Osteoarthritis                                                         | Added prior to 9/1/2019   |                         |
| J7322               | 24 MG/3ML SOSY J7322 Hyaluronan or derivative, for intra-articular injection, 1 mg                  | History and physical, chart notes from ordering physician, treatment plan including condition being treated.                                                                                                                                                                                                                  | Medical Drug               | BCBS Medical Policy, MCG, Medicare NCD/LCD Guidelines                                                                           | RX501.049                | Viscosupplementation for Osteoarthritis                                                         | Added prior to 9/1/2019   |                         |
| J7323               | Hyaluronan or derivative, euflexxa, for intra-articular injection, per dose                         | History and physical, chart notes from ordering physician, treatment plan including condition being treated.                                                                                                                                                                                                                  | Medical Drug               | BCBS Medical Policy, MCG, Medicare NCD/LCD Guidelines                                                                           | RX501.049                | Viscosupplementation for Osteoarthritis                                                         | 9/1/2020                  |                         |
| J7324               | Hyaluronan or derivative, orthovisc, for intra-articular injection, per dose                        | History and physical, chart notes from ordering physician, treatment plan including condition being treated.                                                                                                                                                                                                                  | Medical Drug               | BCBS Medical Policy, MCG, Medicare NCD/LCD Guidelines                                                                           | RX501.050                | Viscosupplementation for Osteoarthritis                                                         | Added prior to 9/1/2019   |                         |
| J7325               | Hyaluronan or derivative, synvisc or synvisc-one, for intra-articular injection, 1 mg               | History and physical, chart notes from ordering physician, treatment plan including condition being treated.                                                                                                                                                                                                                  | Medical Drug               | BCBS Medical Policy, MCG, Medicare NCD/LCD Guidelines                                                                           | RX501.051                | Viscosupplementation for Osteoarthritis                                                         | Added prior to 9/1/2019   |                         |
| J7326               | Hyaluronan or derivative, gel-one, for intra-articular injection, per dose                          | History and physical, chart notes from ordering physician, treatment plan including condition being treated.                                                                                                                                                                                                                  | Medical Drug               | BCBS Medical Policy, MCG, Medicare NCD/LCD Guidelines                                                                           | RX501.052                | Viscosupplementation for Osteoarthritis                                                         | Added prior to 9/1/2019   |                         |
| J7327               | Hyaluronan or derivative, monovisc, for intra-articular injection, per dose                         | History and physical, chart notes from ordering physician, treatment plan including condition being treated.                                                                                                                                                                                                                  | Medical Drug               | BCBS Medical Policy, MCG, Medicare NCD/LCD Guidelines                                                                           | RX501.053                | Viscosupplementation for Osteoarthritis                                                         | Added prior to 9/1/2019   |                         |
| J7328               | Hyaluronan or derivative, for intra-articular injection, 0.1 mg                                     | History and physical, chart notes from ordering physician, treatment plan including condition being treated.                                                                                                                                                                                                                  | Medical Drug               | BCBS Medical Policy, MCG, Medicare NCD/LCD Guidelines                                                                           | RX501.053                | Viscosupplementation for Osteoarthritis                                                         | Added prior to 9/1/2019   |                         |
| J7329               | TriVisc                                                                                             | History and physical, chart notes from ordering physician, treatment plan including condition being treated.                                                                                                                                                                                                                  | Medical Drug               | BCBS Medical Policy, MCG, Medicare NCD/LCD Guidelines                                                                           | RX501.054                | Viscosupplementation for Osteoarthritis                                                         | 1/1/2020                  |                         |
| J7331               | Synjoyn                                                                                             | History and physical, chart notes from ordering physician, treatment plan including condition being treated.                                                                                                                                                                                                                  | Medical Drug               | BCBS Medical Policy, MCG, Medicare NCD/LCD Guidelines                                                                           | RX501.055                | Viscosupplementation for Osteoarthritis                                                         | 10/1/2019                 |                         |

| CPT and HCPCS Codes | Description of Procedure Code                                          | Medical Records Request Information Required                                                                 | Clinical Criteria Category | Clinical Criteria Hierarchy                                                        | Medical Policy Number | Medical Policy Name                                              | Effective and Change Date | Date Posted to Website* |
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| J7332               | Hyaluronan or derivative, triluon, for intra-articular injection, 1 mg | History and physical, chart notes from ordering physician, treatment plan including condition being treated. | Medical Drug               | BCBS Medical Policy, MCG, Medicare NCD/LCD Guidelines                              | RX501.056             | Viscosupplementation for Osteoarthritis                          | 9/1/2020                  |                         |
| J7351               | Injection, bimatoprost, intracameral implant, 1 microgram              | Recent history and physical, plan of care, and documentation of medical necessity.                           | Medical Drug               | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines | OTH903.024            | <a href="#">Intravitreal, Punctum, and Intracameral Implants</a> | Change 11/1/2025          | 9/1/2025                |
| J7352               | Scenese                                                                | History and physical, chart notes from ordering physician, treatment plan including condition being treated. | Medical Drug               | BCBS Medical Policy, MCG, Medicare NCD/LCD Guidelines                              | No medical policy     | No medical policy                                                | 10/1/2021                 |                         |
| J9021               | Asparaginase Erwinia Chrysanthemi (Recombinant)-rvwn                   | Carelon-https://providerportal.com/ or 866-455-8415                                                          | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon               | Carelon                                                          | Change 8/1/2025           |                         |
| J9022               | atezolizumab, 10 mg                                                    | Carelon-https://providerportal.com/ or 866-455-8415                                                          | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon               | Carelon                                                          | Change 8/1/2025           |                         |
| J9023               | Avelumab                                                               | Carelon-https://providerportal.com/ or 866-455-8415                                                          | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon               | Carelon                                                          | Change 8/1/2025           |                         |
| J9032               | Belinostat                                                             | Carelon-https://providerportal.com/ or 866-455-8415                                                          | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon               | Carelon                                                          | Change 8/1/2025           |                         |
| J9035               | Bevacizumab                                                            | Carelon-https://providerportal.com/ or 866-455-8415                                                          | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon               | Carelon                                                          | Change 8/1/2025           |                         |
| J9039               | Blinatumomab                                                           | Carelon-https://providerportal.com/ or 866-455-8415                                                          | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon               | Carelon                                                          | Change 8/1/2025           |                         |
| J9042               | Brentuximab Vedotin                                                    | Carelon-https://providerportal.com/ or 866-455-8415                                                          | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon               | Carelon                                                          | Change 8/1/2025           |                         |
| J9043               | Cabazitaxel                                                            | Carelon-https://providerportal.com/ or 866-455-8415                                                          | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon               | Carelon                                                          | Change 8/1/2025           |                         |
| J9047               | Injection, carfilzomib, 1 mg                                           | Carelon-https://providerportal.com/ or 866-455-8415                                                          | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon               | Carelon                                                          | Change 8/1/2025           |                         |
| J9055               | Injection, cetuximab, 10 mg                                            | Carelon-https://providerportal.com/ or 866-455-8415                                                          | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon               | Carelon                                                          | Change 8/1/2025           |                         |
| J9061               | Amivantamab-vmjw                                                       | Carelon-https://providerportal.com/ or 866-455-8415                                                          | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon               | Carelon                                                          | Change 8/1/2025           |                         |
| J9063               | Mirvetuximab Soravtansine-gynx                                         | Carelon-https://providerportal.com/ or 866-455-8415                                                          | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon               | Carelon                                                          | Change 8/1/2025           |                         |
| J9118               | Calaspargase Pegol-mknl                                                | Carelon-https://providerportal.com/ or 866-455-8415                                                          | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon               | Carelon                                                          | Change 8/1/2025           |                         |
| J9119               | Cemiplimab-rwlc                                                        | Carelon-https://providerportal.com/ or 866-455-8415                                                          | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon               | Carelon                                                          | Change 8/1/2025           |                         |
| J9144               | DARZALEX                                                               | Carelon-https://providerportal.com/ or 866-455-8415                                                          | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon               | Carelon                                                          | Change 8/1/2025           |                         |
| J9145               | DARZALEX                                                               | Carelon-https://providerportal.com/ or 866-455-8415                                                          | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon               | Carelon                                                          | Change 8/1/2025           |                         |
| J9153               | Daunorubicin-Cytarabine Liposome                                       | Carelon-https://providerportal.com/ or 866-455-8415                                                          | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon               | Carelon                                                          | Change 8/1/2025           |                         |
| J9173               | IMFINZI                                                                | Carelon-https://providerportal.com/ or 866-455-8415                                                          | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon               | Carelon                                                          | Change 8/1/2025           |                         |
| J9176               | Elotuzumab                                                             | Carelon-https://providerportal.com/ or 866-455-8415                                                          | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon               | Carelon                                                          | Change 8/1/2025           |                         |
| J9177               | PADCEV                                                                 | Carelon-https://providerportal.com/ or 866-455-8415                                                          | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon               | Carelon                                                          | Change 8/1/2025           |                         |
| J9179               | Eribulin Mesylate                                                      | Carelon-https://providerportal.com/ or 866-455-8415                                                          | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon               | Carelon                                                          | Change 8/1/2025           |                         |
| J9203               | Gemtuzumab Ozogamicin                                                  | Carelon-https://providerportal.com/ or 866-455-8415                                                          | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon               | Carelon                                                          | Change 8/1/2025           |                         |
| J9204               | Mogamulizumab-kpkc                                                     | Carelon-https://providerportal.com/ or 866-455-8415                                                          | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon               | Carelon                                                          | Change 8/1/2025           |                         |
| J9205               | Irinotecan HCl Liposome                                                | Carelon-https://providerportal.com/ or 866-455-8415                                                          | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon               | Carelon                                                          | Change 8/1/2025           |                         |
| J9207               | Ixabepilone                                                            | Carelon-https://providerportal.com/ or 866-455-8415                                                          | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon               | Carelon                                                          | Change 8/1/2025           |                         |
| J9216               | Actimmune                                                              | History and physical, chart notes from ordering physician, treatment plan including condition being treated. | Medical Drug               | BCBS Medical Policy, MCG, Medicare NCD/LCD Guidelines                              | RX502.062             | Oncology Medications                                             | Added 1/1/2025            |                         |
| J9223               | Lurbinectedin                                                          | Carelon-https://providerportal.com/ or 866-455-8415                                                          | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                           | Carelon               | Carelon                                                          | Change 8/1/2025           |                         |

| CPT and HCPCS Codes | Description of Procedure Code             | Medical Records Request Information Required                                                                                                                                                                                                      | Clinical Criteria Category | Clinical Criteria Hierarchy                                                         | Medical Policy Number  | Medical Policy Name                                                             | Effective and Change Date | Date Posted to Website* |
|---------------------|-------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-------------------------------------------------------------------------------------|------------------------|---------------------------------------------------------------------------------|---------------------------|-------------------------|
| J9227               | Isatuximab-irfc                           | Carelon-https://providerportal.com/ or 866-455-8415                                                                                                                                                                                               | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                            | Carelon                | Carelon                                                                         | Change 8/1/2025           |                         |
| J9228               | YERVOY                                    | Carelon-https://providerportal.com/ or 866-455-8415                                                                                                                                                                                               | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                            | Carelon                | Carelon                                                                         | Change 8/1/2025           |                         |
| J9229               | Inotuzumab Ozogamicin                     | Carelon-https://providerportal.com/ or 866-455-8415                                                                                                                                                                                               | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                            | Carelon                | Carelon                                                                         | Change 8/1/2025           |                         |
| J9264               | ABRAXANE                                  | Carelon-https://providerportal.com/ or 866-455-8415                                                                                                                                                                                               | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                            | Carelon                | Carelon                                                                         | Change 8/1/2025           |                         |
| J9266               | Pegaspargase                              | Carelon-https://providerportal.com/ or 866-455-8415                                                                                                                                                                                               | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                            | Carelon                | Carelon                                                                         | Change 8/1/2025           |                         |
| J9269               | Tagraxofusp-erzs                          | Carelon-https://providerportal.com/ or 866-455-8415                                                                                                                                                                                               | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                            | Carelon                | Carelon                                                                         | Change 8/1/2025           |                         |
| J9271               | KEYTRUDA                                  | Carelon-https://providerportal.com/ or 866-455-8415                                                                                                                                                                                               | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                            | Carelon                | Carelon                                                                         | Change 8/1/2025           |                         |
| J9272               | Dostarlimab-gxly                          | Carelon-https://providerportal.com/ or 866-455-8415                                                                                                                                                                                               | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                            | Carelon                | Carelon                                                                         | Change 8/1/2025           |                         |
| J9273               | Tisotumab Vedotin-tftv                    | Carelon-https://providerportal.com/ or 866-455-8415                                                                                                                                                                                               | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                            | Carelon                | Carelon                                                                         | Change 8/1/2025           |                         |
| J9274               | Tebentafusp-tebn                          | Carelon-https://providerportal.com/ or 866-455-8415                                                                                                                                                                                               | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                            | Carelon                | Carelon                                                                         | Change 8/1/2025           |                         |
| J9281               | Mitomycin instillation                    | Carelon-https://providerportal.com/ or 866-455-8415                                                                                                                                                                                               | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                            | Carelon                | Carelon                                                                         | Change 8/1/2025           |                         |
| J9286               | Glofitamab-gxbm                           | Carelon-https://providerportal.com/ or 866-455-8415                                                                                                                                                                                               | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                            | Carelon                | Carelon                                                                         | Change 8/1/2025           |                         |
| J9295               | Necitumumab                               | Carelon-https://providerportal.com/ or 866-455-8415                                                                                                                                                                                               | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                            | Carelon                | Carelon                                                                         | Change 8/1/2025           |                         |
| J9298               | Nivolumab-Relatlimab-rmbw                 | Carelon-https://providerportal.com/ or 866-455-8415                                                                                                                                                                                               | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                            | Carelon                | Carelon                                                                         | Change 8/1/2025           |                         |
| J9299               | OPDIVO                                    | Carelon-https://providerportal.com/ or 866-455-8415                                                                                                                                                                                               | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                            | Carelon                | Carelon                                                                         | Change 8/1/2025           |                         |
| J9301               | Obinutuzumab                              | Carelon-https://providerportal.com/ or 866-455-8415                                                                                                                                                                                               | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                            | Carelon                | Carelon                                                                         | Change 8/1/2025           |                         |
| J9302               | Ofatumumab                                | Carelon-https://providerportal.com/ or 866-455-8415                                                                                                                                                                                               | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                            | Carelon                | Carelon                                                                         | Change 8/1/2025           |                         |
| J9303               | Panitumumab                               | Carelon-https://providerportal.com/ or 866-455-8415                                                                                                                                                                                               | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                            | Carelon                | Carelon                                                                         | Change 8/1/2025           |                         |
| J9306               | PERJETA                                   | Carelon-https://providerportal.com/ or 866-455-8415                                                                                                                                                                                               | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                            | Carelon                | Carelon                                                                         | Change 8/1/2025           |                         |
| J9308               | Ramucirumab                               | Carelon-https://providerportal.com/ or 866-455-8415                                                                                                                                                                                               | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                            | Carelon                | Carelon                                                                         | Change 8/1/2025           |                         |
| J9309               | Polatuzumab Vedotin-piiq                  | Carelon-https://providerportal.com/ or 866-455-8415                                                                                                                                                                                               | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                            | Carelon                | Carelon                                                                         | Change 8/1/2025           |                         |
| J9311               | Rituximab-Hyaluronidase Human             | Carelon-https://providerportal.com/ or 866-455-8415                                                                                                                                                                                               | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                            | Carelon                | Carelon                                                                         | Change 8/1/2025           |                         |
| J9312               | Immunomodulators                          | Carelon-https://providerportal.com/ or 866-455-8415 Carelon will review requests for oncology drugs that are supported by an oncology diagnosis. If the drug requested is not associated with an oncology diagnosis, it will be reviewed by BCBS. | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                            | Carelon                | Carelon                                                                         | 10/1/2025                 | 9/1/2025                |
| J9312               | Immunomodulators                          | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity                                                                                                                                        | Medical Drug               | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | RX502.061<br>RX502.030 | Oncology Medications    Rituximab and Biosimilars for Non-Oncologic Indications | Added 11/1/2025           | 9/1/2025                |
| J9316               | Pertuzumab-Trastuzumab-Hyaluronidase-zzxf | Carelon-https://providerportal.com/ or 866-455-8415                                                                                                                                                                                               | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                            | Carelon                | Carelon                                                                         | Change 8/1/2025           |                         |
| J9317               | Sacituzumab Govitecan-hziy                | Carelon-https://providerportal.com/ or 866-455-8415                                                                                                                                                                                               | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                            | Carelon                | Carelon                                                                         | Change 8/1/2025           |                         |
| J9321               | Epcoritamab-bysp                          | Carelon-https://providerportal.com/ or 866-455-8415                                                                                                                                                                                               | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                            | Carelon                | Carelon                                                                         | Change 8/1/2025           |                         |
| J9325               | Talimogene Laherparepvec                  | Carelon-https://providerportal.com/ or 866-455-8415                                                                                                                                                                                               | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                            | Carelon                | Carelon                                                                         | Change 8/1/2025           |                         |
| J9331               | Sirolimus Protein-Bound Particles         | Carelon-https://providerportal.com/ or 866-455-8415                                                                                                                                                                                               | Medical Oncology           | https://guidelines.carelonmedicalbenefitsmanagement.com/                            | Carelon                | Carelon                                                                         | Change 8/1/2025           |                         |

| CPT and HCPCS Codes | Description of Procedure Code                             | Medical Records Request Information Required                                                               | Clinical Criteria Category | Clinical Criteria Hierarchy                                                                                                     | Medical Policy Number           | Medical Policy Name                                                                                                                                                                                | Effective and Change Date | Date Posted to Website* |
|---------------------|-----------------------------------------------------------|------------------------------------------------------------------------------------------------------------|----------------------------|---------------------------------------------------------------------------------------------------------------------------------|---------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------|
| J9332               | Vyvgart                                                   | SRU                                                                                                        | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.141 RX501.056 ADM1001.034 | Efgartigimod alfa-fcab or Efgartigimod alfa and hyaluronidase-qvfc<br>Advanced Therapies for Pharmacologic Treatment of Pulmonary Hypertension<br>Specialty Medication Administration Site of Care | Added 7/1/2023            |                         |
| J9333               | Injection, rozanolixizumab-noli, 1 mg                     | SRU                                                                                                        | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.161                       | Rozanolixizumab-noli                                                                                                                                                                               | 1/1/2024                  |                         |
| J9334               | Injection, efgartigimod alfa, 2 mg and hyaluronidase-qvfc | SRU                                                                                                        | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.141                       | Efgartigimod alfa-fcab or Efgartigimod alfa and hyaluronidase-qvfc                                                                                                                                 | 1/1/2024                  |                         |
| J9345               | Retifanlimab-dlwr                                         | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415             | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                         | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| J9347               | Tremelimumab-actl                                         | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415             | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                         | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| J9348               | Naxitamab-gqgk                                            | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415             | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                         | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| J9349               | Tafasitamab-cxix                                          | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415             | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                         | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| J9350               | Mosunetuzumab-axgb                                        | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415             | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                         | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| J9352               | Trabectedin                                               | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415             | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                         | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| J9353               | Margetuximab-cmkb                                         | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415             | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                         | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| J9354               | Ado-Trastuzumab Emtansine                                 | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415             | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                         | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| J9355               | Trastuzumab                                               | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415             | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                         | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| J9356               | Trastuzumab-Hyaluronidase-oyks                            | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415             | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                         | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| J9358               | ENHERTU                                                   | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415             | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                         | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| J9359               | Loncastuximab Tesirine-lpyl                               | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415             | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                         | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| J9376               | Injection, paclitaxel, 1 mg                               | SRU                                                                                                        | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.087                       | FDA-Approved Drugs, Biologicals, Cellular and Gene Therapies                                                                                                                                       | 4/1/2024                  |                         |
| J9380               | Teclistamab-cqyv                                          | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415             | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                         | Carelon                                                                                                                                                                                            | Change 8/1/2025           |                         |
| J9381               | Injection, teplizumab-mzww, 5 mcg                         | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity | Medical Drug               | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.150                       | <a href="#">Teplizumab-mzww</a>                                                                                                                                                                    | Change 11/1/2025          | 9/1/2025                |
| J9999               | Unclassified, non-oncology use                            | Recent history and physical, plan of care, and documentation of medical necessity.                         | Medical Drug               | BCBS Medical Policy, MCG, Medicare NCD/LCD Guidelines                                                                           | RX501.087                       | FDA-Approved Drugs and Biologicals                                                                                                                                                                 | Added internal 1/1/24     |                         |

| CPT and HCPCS Codes | Description of Procedure Code                                                                                                                                  | Medical Records Request Information Required                                                                                                                                                                                                                                                                                                                                                       | Clinical Criteria Category | Clinical Criteria Hierarchy                                                         | Medical Policy Number | Medical Policy Name                  | Effective and Change Date | Date Posted to Website* |
|---------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-------------------------------------------------------------------------------------|-----------------------|--------------------------------------|---------------------------|-------------------------|
| K0004               | High strength, lightweight wheelchair                                                                                                                          | History and physical or clinical notes, including anticipated length of use.                                                                                                                                                                                                                                                                                                                       | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories          | Added prior to 9/1/2019   |                         |
| K0005               | Ultralightweight wheelchair                                                                                                                                    | History and physical or clinical notes, including anticipated length of use.                                                                                                                                                                                                                                                                                                                       | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories          | Added prior to 9/1/2019   |                         |
| K0006               | Heavy-duty wheelchair                                                                                                                                          | History and physical or clinical notes, including anticipated length of use.                                                                                                                                                                                                                                                                                                                       | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories          | Added prior to 9/1/2019   |                         |
| K0007               | Extra heavy-duty wheelchair                                                                                                                                    | History and physical or clinical notes, including anticipated length of use.                                                                                                                                                                                                                                                                                                                       | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories          | Added prior to 9/1/2019   |                         |
| K0008               | Custom manual wheelchair/base                                                                                                                                  | History and physical or clinical notes, including anticipated length of use.                                                                                                                                                                                                                                                                                                                       | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories          | Added prior to 9/1/2019   |                         |
| K0009               | Other manual wheelchair/base                                                                                                                                   | History and physical or clinical notes, including anticipated length of use.                                                                                                                                                                                                                                                                                                                       | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories          | Added prior to 9/1/2019   |                         |
| K0010               | Standard-weight frame motorized/power wheelchair                                                                                                               | History and physical or clinical notes, including anticipated length of use.                                                                                                                                                                                                                                                                                                                       | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories          | Added prior to 9/1/2019   |                         |
| K0011               | Standard-weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking | History and physical or clinical notes, including anticipated length of use.                                                                                                                                                                                                                                                                                                                       | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories          | Added prior to 9/1/2019   |                         |
| K0012               | Lightweight portable motorized/power wheelchair                                                                                                                | History and physical or clinical notes, including anticipated length of use.                                                                                                                                                                                                                                                                                                                       | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories          | Added prior to 9/1/2019   |                         |
| K0013               | Custom motorized/power wheelchair base                                                                                                                         | History and physical or clinical notes, including anticipated length of use.                                                                                                                                                                                                                                                                                                                       | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories          | Added prior to 9/1/2019   |                         |
| K0014               | OTHER MOTORIZED/POWER WHEELCHAIR BASE                                                                                                                          | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. Documented inability to propel a manual chair. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories          | Added prior to 9/1/2019   |                         |
| K0108               | Wheelchair component or accessory, not otherwise specified                                                                                                     | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. Documented inability to propel a manual chair. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories          | Added prior to 9/1/2019   |                         |
| K0606               | Aed garment w elec analysis                                                                                                                                    | Recent history and physical, plan of care, and documentation of medical necessity.                                                                                                                                                                                                                                                                                                                 | Durable Medical Equipment  | Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                      |                       | Cardioverter-Defibrillator, Wearable | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code                                                                                                                               | Medical Records Request Information Required                                                                                                                                                                                                                                                                                                        | Clinical Criteria Category | Clinical Criteria Hierarchy                                                         | Medical Policy Number | Medical Policy Name         | Effective and Change Date | Date Posted to Website* |
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| K0739               | Repair or nonroutine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes | Recent History and Physical, plan of care, and documentation of medical necessity                                                                                                                                                                                                                                                                   | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0800               | Power operated vehicle, group 1 standard, patient weight capacity up to and including 300 pounds                                                            | Recent History and Physical, plan of care, and documentation of medical necessity                                                                                                                                                                                                                                                                   | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0801               | Power operated vehicle, group 1 heavy duty, patient weight capacity 301 to 450 pounds                                                                       | Recent history and physical, plan of care, and documentation of medical necessity.                                                                                                                                                                                                                                                                  | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0806               | Power operated vehicle, group 2 standard, patient weight capacity up to and including 300 pounds                                                            | Recent History and Physical, plan of care, and documentation of medical necessity                                                                                                                                                                                                                                                                   | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0808               | Power operated vehicle, group 2 very heavy duty, patient weight capacity 451 to 600 pounds                                                                  | Recent history and physical, plan of care, and documentation of medical necessity.                                                                                                                                                                                                                                                                  | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0812               | Power operated vehicle, not otherwise classified                                                                                                            | Recent History and Physical, plan of care, and documentation of medical necessity                                                                                                                                                                                                                                                                   | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0813               | Power wheelchair, group 1 standard, portable, sling/solid seat and back, patient weight capacity up to and including 300 pounds                             | History and physical or clinical notes, including anticipated length of use.                                                                                                                                                                                                                                                                        | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0814               | Power wheelchair, group 1 standard, portable, captain's chair, patient weight capacity up to and including 300 pounds                                       | Recent history and physical, plan of care, and documentation of medical necessity.                                                                                                                                                                                                                                                                  | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0815               | Power wheelchair, group 1 standard, sling/solid seat and back, patient weight capacity up to and including 300 pounds                                       | Recent history and physical, plan of care, and documentation of medical necessity.                                                                                                                                                                                                                                                                  | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0816               | Power wheelchair, group 1 standard, captain's chair, patient weight capacity up to and including 300 pounds                                                 | Recent history and physical, plan of care, and documentation of medical necessity.                                                                                                                                                                                                                                                                  | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0820               | Power wheelchair, group 2 standard, portable, sling/solid seat/back, patient weight capacity up to and including 300 pounds                                 | Recent history and physical, plan of care, and documentation of medical necessity.                                                                                                                                                                                                                                                                  | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0821               | Power wheelchair, group 2 standard, portable, captain's chair, patient weight capacity up to and including 300 pounds                                       | Recent history and physical, plan of care, and documentation of medical necessity.                                                                                                                                                                                                                                                                  | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0822               | POWER WHEELCHAIR, GROUP 2 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS                                           | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code                                                                                                          | Medical Records Request Information Required                                                                                                                                                                                                                                                                                                        | Clinical Criteria Category | Clinical Criteria Hierarchy                                                         | Medical Policy Number | Medical Policy Name         | Effective and Change Date | Date Posted to Website* |
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| K0823               | Power wheelchair, group 2 standard, captain's chair, patient weight capacity up to and including 300 pounds                            | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0824               | Power wheelchair, group 2 heavy-duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds                                 | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0825               | Power wheelchair, group 2 heavy-duty, captain's chair, patient weight capacity 301 to 450 pounds                                       | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0826               | Power wheelchair, group 2 very heavy-duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds                            | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0827               | Power wheelchair, group 2 very heavy-duty, captain's chair, patient weight capacity 451 to 600 pounds                                  | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0828               | Power wheelchair, group 2 extra heavy-duty, sling/solid seat/back, patient weight capacity 601 pounds or more                          | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0829               | Power wheelchair, group 2 extra heavy-duty, captain's chair, patient weight 601 pounds or more                                         | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0830               | Power wheelchair, group 2 standard, seat elevator, sling/solid seat/back, patient weight capacity up to and including 300 pounds       | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0831               | Power wheelchair, group 2 standard, seat elevator, captain's chair, patient weight capacity up to and including 300 pounds             | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0835               | POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code                                                                                                            | Medical Records Request Information Required                                                                                                                                                                                                                                                                                                        | Clinical Criteria Category | Clinical Criteria Hierarchy                                                         | Medical Policy Number | Medical Policy Name         | Effective and Change Date | Date Posted to Website* |
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| K0836               | Power wheelchair, group 2 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds         | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0837               | Power wheelchair, group 2 heavy-duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds              | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0838               | Power wheelchair, group 2 heavy-duty, single power option, captain's chair, patient weight capacity 301 to 450 pounds                    | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0839               | Power wheelchair, group 2 very heavy-duty, single power option sling/solid seat/back, patient weight capacity 451 to 600 pounds          | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0840               | Power wheelchair, group 2 extra heavy-duty, single power option, sling/solid seat/back, patient weight capacity 601 pounds or more       | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0841               | Power wheelchair, group 2 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0842               | Power wheelchair, group 2 standard, multiple power option, captain's chair, patient weight capacity up to and including 300 pounds       | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0843               | Power wheelchair, group 2 heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds            | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0848               | POWER WHEELCHAIR, GROUP 3 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS                        | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0849               | Power wheelchair, group 3 standard, captains chair, patient weight capacity up to and including 300 pounds                               | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code                                                                                                          | Medical Records Request Information Required                                                                                                                                                                                                                                                                                                        | Clinical Criteria Category | Clinical Criteria Hierarchy                                                         | Medical Policy Number | Medical Policy Name         | Effective and Change Date | Date Posted to Website* |
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| K0850               | Power wheelchair, group 3 heavy-duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds                                 | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0851               | Power wheelchair, group 3 heavy-duty, captain's chair, patient weight capacity 301 to 450 pounds                                       | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0852               | Power wheelchair, group 3 very heavy-duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds                            | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0853               | Power wheelchair, group 3 very heavy-duty, captain's chair, patient weight capacity 451 to 600 pounds                                  | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0854               | Power wheelchair, group 3 extra heavy-duty, sling/solid seat/back, patient weight capacity 601 pounds or more                          | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0855               | Power wheelchair, group 3 extra heavy-duty, captain's chair, patient weight capacity 601 pounds or more                                | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0856               | POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0856               | Power wheelchair, group 3 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0857               | Power wheelchair, group 3 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds       | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0858               | Power wheelchair, group 3 heavy-duty, single power option, sling/solid seat/back, patient weight 301 to 450 pounds                     | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code                                                                                                            | Medical Records Request Information Required                                                                                                                                                                                                                                                                                                        | Clinical Criteria Category | Clinical Criteria Hierarchy                                                         | Medical Policy Number | Medical Policy Name         | Effective and Change Date | Date Posted to Website* |
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| K0859               | Power wheelchair, group 3 heavy-duty, single power option, captain's chair, patient weight capacity 301 to 450 pounds                    | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0860               | Power wheelchair, group 3 very heavy-duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds         | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0861               | POWER WHEELCHAIR, GROUP 3 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0862               | POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS            | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0863               | Power wheelchair, group 3 very heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds       | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0864               | Power wheelchair, group 3 extra heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 601 pounds or more     | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0868               | POWER WHEELCHAIR, GROUP 4 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS                        | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0869               | Power wheelchair, group 4 standard, captain's chair, patient weight capacity up to and including 300 pounds                              | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0870               | Power wheelchair, group 4 heavy-duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds                                   | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0871               | Power wheelchair, group 4 very heavy-duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds                              | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code                                                                                                             | Medical Records Request Information Required                                                                                                                                                                                                                                                                                                        | Clinical Criteria Category | Clinical Criteria Hierarchy                                                         | Medical Policy Number | Medical Policy Name         | Effective and Change Date | Date Posted to Website* |
|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-------------------------------------------------------------------------------------|-----------------------|-----------------------------|---------------------------|-------------------------|
| K0877               | Power wheelchair, group 4 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds    | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0878               | Power wheelchair, group 4 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds          | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0879               | Power wheelchair, group 4 heavy-duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds               | History and physical or clinical notes, including anticipated length of use.                                                                                                                                                                                                                                                                        | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0880               | Power wheelchair, group 4 very heavy-duty, single power option, sling/solid seat/back, patient weight 451 to 600                          | History and physical or clinical notes, including anticipated length of use.                                                                                                                                                                                                                                                                        | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0884               | POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS  | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0885               | Power wheelchair, group 4 standard, multiple power option, captain's chair, patient weight capacity up to and including 300 pounds        | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0886               | Power wheelchair, group 4 heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds             | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0890               | POWER WHEELCHAIR, GROUP 5 PEDIATRIC, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS   | History and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0891               | Power wheelchair, group 5 pediatric, multiple power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds | History and physical or clinical notes, including anticipated length of use.                                                                                                                                                                                                                                                                        | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0898               | Power wheelchair, not otherwise classified                                                                                                | History and physical or clinical notes, including anticipated length of use.                                                                                                                                                                                                                                                                        | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |
| K0899               | Power mobility device, not coded by DME PDAC or does not meet criteria                                                                    | History and physical or clinical notes, including anticipated length of use.                                                                                                                                                                                                                                                                        | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME101.010            | Wheelchairs and Accessories | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code                                                                                                                                          | Medical Records Request Information Required                                                                                                 | Clinical Criteria Category | Clinical Criteria Hierarchy                                                         | Medical Policy Number | Medical Policy Name                                                     | Effective and Change Date | Date Posted to Website* |
|---------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-------------------------------------------------------------------------------------|-----------------------|-------------------------------------------------------------------------|---------------------------|-------------------------|
| L5707               | Custom shaped protective cover, hip disarticulation                                                                                                                    | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.012            | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | Added prior to 9/1/2019   |                         |
| L5780               | Addition, exoskeletal knee-shin system, single axis, pneumatic/hydra pneumatic swing phase control                                                                     | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.012            | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | Added prior to 9/1/2019   |                         |
| L5781               | Addition to lower limb prosthesis, vacuum pump, residual limb volume management and moisture evacuation system                                                         | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.012            | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | Added prior to 9/1/2019   |                         |
| L5782               | Addition to lower limb prosthesis, vacuum pump, residual limb volume management and moisture evacuation system, heavy duty                                             | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.012            | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | Added prior to 9/1/2019   |                         |
| L5814               | Addition, endoskeletal knee-shin system, polycentric, hydraulic swing phase control, mechanical stance phase lock                                                      | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.012            | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | Added prior to 9/1/2019   |                         |
| L5826               | Addition, endoskeletal knee-shin system, single axis, hydraulic swing phase control, with miniature high activity frame                                                | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.012            | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | Added prior to 9/1/2019   |                         |
| L5828               | Addition, endoskeletal knee-shin system, single axis, fluid swing and stance phase control                                                                             | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.012            | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | Added prior to 9/1/2019   |                         |
| L5830               | Addition, endoskeletal knee-shin system, single axis, pneumatic/swing phase control                                                                                    | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.012            | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | Added prior to 9/1/2019   |                         |
| L5840               | Addition, endoskeletal knee/shin system, 4-bar linkage or multiaxial, pneumatic swing phase control                                                                    | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.012            | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | Added prior to 9/1/2019   |                         |
| L5845               | Addition, endoskeletal, knee-shin system, stance flexion feature, adjustable                                                                                           | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.012            | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | Added prior to 9/1/2019   |                         |
| L5856               | ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE-SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, SWING AND STANCE PHASE, INCLUDES ELECTRONIC SENSOR(S), ANY TYPE | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.012            | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | Added prior to 9/1/2019   |                         |
| L5857               | Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing phase only, includes electronic sensor(s), any type       | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.012            | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code                                                                                                                                     | Medical Records Request Information Required                                                                                                 | Clinical Criteria Category | Clinical Criteria Hierarchy                                                         | Medical Policy Number | Medical Policy Name                                                     | Effective and Change Date | Date Posted to Website* |
|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-------------------------------------------------------------------------------------|-----------------------|-------------------------------------------------------------------------|---------------------------|-------------------------|
| L5858               | Addition to lower extremity prosthesis, endoskeletal knee shin system, microprocessor control feature, stance phase only, includes electronic sensor(s), any type | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.012            | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | Added prior to 9/1/2019   |                         |
| L5859               | Addition to lower extremity prosthesis, endoskeletal knee shin system, powered and programmable flexion/extension assist control, includes any type motor(s)      | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.012            | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | Added prior to 9/1/2019   |                         |
| L5880               | Preparatory, above knee - knee disarticulation ischial level socket, non-alignable system, pylon, no cover, sach foot, thermoplastic or equal, molded to model    | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.012            | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | Added prior to 9/1/2019   |                         |
| L5910               | Addition, endoskeletal system, below knee, alignable system                                                                                                       | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.012            | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | Added prior to 9/1/2019   |                         |
| L5920               | Addition, endoskeletal system, above knee or hip disarticulation, alignable system                                                                                | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.012            | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | Added prior to 9/1/2019   |                         |
| L5930               | Addition, endoskeletal system, high activity knee control frame                                                                                                   | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.012            | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | Added prior to 9/1/2019   |                         |
| L5940               | Addition, endoskeletal system, below knee, ultra-light material (titanium, carbon fiber or equal)                                                                 | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.012            | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | Added prior to 9/1/2019   |                         |
| L5950               | Addition, endoskeletal system, above knee, ultra-light material (titanium, carbon fiber or equal)                                                                 | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.012            | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | Added prior to 9/1/2019   |                         |
| L5960               | Addition, endoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal)                                                        | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.012            | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | Added prior to 9/1/2019   |                         |
| L5961               | Addition, endoskeletal system, polycentric hip joint, pneumatic or hydraulic control, rotation control, with or without flexion and/or extension control          | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.012            | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | Added prior to 9/1/2019   |                         |
| L5962               | Addition, endoskeletal system, below knee, flexible protective outer surface covering system                                                                      | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.012            | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | Added prior to 9/1/2019   |                         |
| L5964               | Addition, endoskeletal system, above knee, flexible protective outer surface covering system                                                                      | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.012            | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | Added prior to 9/1/2019   |                         |
| L5968               | Addition to lower limb prosthesis, multiaxial ankle with swing phase active dorsiflexion feature                                                                  | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.012            | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code                                                                                                                                                                                                             | Medical Records Request Information Required                                                                                                 | Clinical Criteria Category | Clinical Criteria Hierarchy                                                         | Medical Policy Number | Medical Policy Name                                                                                                          | Effective and Change Date | Date Posted to Website* |
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| L5973               | Endoskeletal ankle foot system, microprocessor controlled feature, dorsiflexion and/or plantar flexion control, includes power source                                                                                                     | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.012            | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics                                                      | Added prior to 9/1/2019   |                         |
| L5979               | All lower extremity prosthesis, multi-axial ankle, dynamic response foot, one piece system                                                                                                                                                | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.012            | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics                                                      | Added prior to 9/1/2019   |                         |
| L5980               | All lower extremity prostheses, flex foot system                                                                                                                                                                                          | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.012            | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics                                                      | Added prior to 9/1/2019   |                         |
| L5981               | All lower extremity prostheses, flex-walk system or equal                                                                                                                                                                                 | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.012            | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics                                                      | Added prior to 9/1/2019   |                         |
| L5987               | All Lower Extremity Prosthesis, Shank Foot System With Vertical Loading Pylon                                                                                                                                                             | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.012            | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics                                                      | Added prior to 9/1/2019   |                         |
| L5988               | Addition to lower limb prosthesis, vertical shock reducing pylon feature                                                                                                                                                                  | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.012            | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics                                                      | Added prior to 9/1/2019   |                         |
| L5990               | Addition to lower extremity prosthesis, user adjustable heel height                                                                                                                                                                       | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.012            | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics                                                      | Added prior to 9/1/2019   |                         |
| L5999               | Lower extremity prosthesis, not otherwise specified                                                                                                                                                                                       | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.012            | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics                                                      | Added prior to 9/1/2019   |                         |
| L6500               | Above elbow, molded socket, endoskeletal system, including soft prosthetic tissue shaping                                                                                                                                                 | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L6550               | Shoulder disarticulation, molded socket, endoskeletal system, including soft prosthetic tissue shaping                                                                                                                                    | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L6570               | Interscapular thoracic, molded socket, endoskeletal system, including soft prosthetic tissue shaping                                                                                                                                      | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L6580               | Preparatory, wrist disarticulation or below elbow, single wall plastic socket, friction wrist, flexible elbow hinges, figure of eight harness, humeral cuff, Bowden cable control, USMC or equal pylon, no cover, molded to patient model | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L6582               | Preparatory, wrist disarticulation or below elbow, single wall socket, friction wrist, flexible elbow hinges, figure of eight harness, humeral cuff, Bowden cable control, USMC or equal pylon, no cover, direct formed                   | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code                                                                                                                                                                                                                                   | Medical Records Request Information Required                                                                                                 | Clinical Criteria Category | Clinical Criteria Hierarchy                                                         | Medical Policy Number | Medical Policy Name                                                                                                          | Effective and Change Date | Date Posted to Website* |
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| L6584               | Preparatory, elbow disarticulation or above elbow, single wall plastic socket, friction wrist, locking elbow, figure of eight harness, fair lead cable control, USMC or equal pylon, no cover, molded to patient model                                          | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L6586               | Preparatory, elbow disarticulation or above elbow, single wall socket, friction wrist, locking elbow, figure of eight harness, fair lead cable control, USMC or equal pylon, no cover, direct formed                                                            | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L6588               | Preparatory, shoulder disarticulation or interscapular thoracic, single wall plastic socket, shoulder joint, locking elbow, friction wrist, chest strap, fair lead cable control, usmc or equal pylon, no cover, molded to patient model                        | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L6590               | Preparatory, shoulder disarticulation or interscapular thoracic, single wall socket, shoulder joint, locking elbow, friction wrist, chest strap, fair lead cable control, USMC or equal pylon, no cover, direct formed                                          | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L6624               | Upper extremity addition, flexion/extension and rotation wrist unit                                                                                                                                                                                             | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L6638               | Upper extremity addition to prosthesis, electric locking feature, only for use with manually powered elbow                                                                                                                                                      | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L6646               | Upper extremity addition, shoulder joint, multipositional locking, flexion, adjustable abduction friction control, for use with body powered or external powered system                                                                                         | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L6648               | Upper extremity addition, shoulder lock mechanism, external powered actuator                                                                                                                                                                                    | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L6693               | Upper extremity addition, locking elbow, forearm counterbalance                                                                                                                                                                                                 | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L6696               | Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than init | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code                                                                                                                                                                                                                                            | Medical Records Request Information Required                                                                                                 | Clinical Criteria Category | Clinical Criteria Hierarchy                                                         | Medical Policy Number | Medical Policy Name                                                                                                          | Effective and Change Date | Date Posted to Website* |
|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-------------------------------------------------------------------------------------|-----------------------|------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------|
| L6697               | Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated socket insert for other than congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for <u>or the</u> | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L6707               | Terminal device, hook, mechanical, voluntary closing, any material, any size, lined or <u>unlined</u>                                                                                                                                                                    | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L6709               | Terminal device, hand, mechanical, voluntary closing, any material, any size                                                                                                                                                                                             | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L6712               | Terminal device, hook, mechanical, voluntary closing, any material, any size, lined or <u>unlined, pediatric</u>                                                                                                                                                         | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L6713               | Terminal device, hand, mechanical, voluntary opening, any material, any size, <u>pediatric</u>                                                                                                                                                                           | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L6714               | Terminal device, hand, mechanical, voluntary closing, any material, any size, <u>pediatric</u>                                                                                                                                                                           | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L6715               | Terminal device, multiple articulating digit, includes motor(s), initial issue or <u>replacement</u>                                                                                                                                                                     | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L6721               | Terminal device, hook or hand, heavy duty, mechanical, voluntary opening, any material, any size, lined or <u>unlined</u>                                                                                                                                                | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L6722               | Terminal device, hook or hand, heavy-duty, mechanical, voluntary closing, any material, any size, lined or <u>unlined</u>                                                                                                                                                | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L6880               | Electric hand, switch or myoelectric controlled, independently articulating digits, any grasp pattern or combination of grasp patterns, <u>includes motor(s)</u>                                                                                                         | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L6881               | Automatic grasp feature, addition to upper limb electric prosthetic terminal device                                                                                                                                                                                      | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L6882               | Microprocessor control feature, addition to upper limb prosthetic terminal device                                                                                                                                                                                        | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L6883               | Replacement socket, below elbow/wrist disarticulation, molded to patient model, for use with or without external <u>power</u>                                                                                                                                            | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code                                                                                                                                                                                           | Medical Records Request Information Required                                                                                                 | Clinical Criteria Category | Clinical Criteria Hierarchy                                                         | Medical Policy Number | Medical Policy Name                                                                                                          | Effective and Change Date | Date Posted to Website* |
|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-------------------------------------------------------------------------------------|-----------------------|------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------|
| L6884               | Replacement socket, above elbow/elbow disarticulation, molded to patient model, for use with or without external power                                                                                                  | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L6885               | Replacement socket, shoulder disarticulation/interscapular thoracic, molded to patient model, for use with or without external power                                                                                    | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L6900               | Hand restoration (casts, shading and measurements included), partial hand, with glove, thumb or one finger remaining                                                                                                    | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L6905               | Hand restoration (casts, shading and measurements included), partial hand, with glove, multiple fingers remaining                                                                                                       | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L6910               | Hand restoration (casts, shading and measurements included), partial hand, with glove, no fingers remaining                                                                                                             | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L6920               | Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, otto bock or equal, switch, cables, two batteries and one charger, switch control of terminal device                       | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L6925               | Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device             | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L6930               | Below elbow, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal switch, cables, 2 batteries and one charger, switch control of terminal device                                    | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L6935               | Below elbow, external power, self-suspended inner socket, removable forearm shell, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device                       | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L6940               | Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, Otto Bock or equal switch, cables, 2 batteries and one charger, switch control of terminal device | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code                                                                                                                                                                                                                                   | Medical Records Request Information Required                                                                                                 | Clinical Criteria Category | Clinical Criteria Hierarchy                                                         | Medical Policy Number | Medical Policy Name                                                                                                          | Effective and Change Date | Date Posted to Website* |
|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-------------------------------------------------------------------------------------|-----------------------|------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------|
| L6945               | Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device                            | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L6950               | Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, otto bock or equal switch, cables, two batteries and one charger, switch control of terminal device                                                 | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L6955               | Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device                                      | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L6960               | Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, otto bock or equal switch, cables, two batteries and one charger, switch control of terminal device     | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L6965               | Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L6970               | Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, otto bock or equal switch, cables, two batteries and one charger, switch control of terminal device       | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code                                                                                                                                                                                                                                        | Medical Records Request Information Required                                                                                                 | Clinical Criteria Category | Clinical Criteria Hierarchy                                                         | Medical Policy Number | Medical Policy Name                                                                                                          | Effective and Change Date | Date Posted to Website* |
|---------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-------------------------------------------------------------------------------------|-----------------------|------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------|
| L6975               | Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L7007               | ELECTRIC HAND, SWITCH OR MYOELECTRIC CONTROLLED, ADULT                                                                                                                                                                                                               | History and physical, letter of medical necessity and functional status eval from physiatrist or physical therapist.                         | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L7008               | Electric hand, switch or myoelectric controlled, pediatric                                                                                                                                                                                                           | History and physical, letter of medical necessity and functional status eval from physiatrist or physical therapist.                         | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L7009               | Electric hook, switch or myoelectric controlled, adult                                                                                                                                                                                                               | History and physical, letter of medical necessity and functional status eval from physiatrist or physical therapist.                         | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L7040               | Prehensile actuator, switch controlled                                                                                                                                                                                                                               | History and physical, letter of medical necessity and functional status eval from physiatrist or physical therapist.                         | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L7045               | Electric hook, switch or myoelectric controlled, pediatric                                                                                                                                                                                                           | History and physical, letter of medical necessity and functional status eval from physiatrist or physical therapist.                         | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L7170               | Electronic elbow, hosmer or equal, switch controlled                                                                                                                                                                                                                 | History and physical, letter of medical necessity and functional status eval from physiatrist or physical therapist.                         | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L7180               | Electronic elbow, microprocessor sequential control of elbow and terminal device                                                                                                                                                                                     | History and physical, letter of medical necessity and functional status eval from physiatrist or physical therapist.                         | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L7181               | Electronic elbow, microprocessor simultaneous control of elbow and terminal device                                                                                                                                                                                   | History and physical, letter of medical necessity and functional status eval from physiatrist or physical therapist.                         | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L7185               | Electronic elbow, adolescent, variety village or equal, switch controlled                                                                                                                                                                                            | History and physical, letter of medical necessity and functional status eval from physiatrist or physical therapist.                         | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L7186               | Electronic elbow, child, variety village or equal, switch controlled                                                                                                                                                                                                 | History and physical, letter of medical necessity and functional status eval from physiatrist or physical therapist.                         | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L7190               | Electronic elbow, adolescent, variety village or equal, myoelectronically controlled                                                                                                                                                                                 | History and physical, letter of medical necessity and functional status eval from physiatrist or physical therapist.                         | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L7191               | Electronic elbow, child, variety village or equal, myoelectronically controlled                                                                                                                                                                                      | History and physical, letter of medical necessity and functional status eval from physiatrist or physical therapist.                         | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L7259               | Electronic wrist rotator, any type                                                                                                                                                                                                                                   | History and physical, letter of medical necessity and functional status eval from physiatrist or physical therapist.                         | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L8040               | Nasal prosthesis, provided by a nonphysician                                                                                                                                                                                                                         | History and physical, letter of medical necessity and functional status eval from physiatrist or physical therapist.                         | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L8041               | Midfacial prosthesis, provided by a nonphysician                                                                                                                                                                                                                     | History and physical, letter of medical necessity and functional status eval from physiatrist or physical therapist.                         | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| L8042               | Orbital prosthesis, provided by a non-physician                                                                                                                                                                                                                      | Letter of medical necessity, including condition being treated.                                                                              | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code                                                                                                                     | Medical Records Request Information Required                                                           | Clinical Criteria Category               | Clinical Criteria Hierarchy                                                         | Medical Policy Number                                                                          | Medical Policy Name                                                                                                                                                                                                                                                             | Effective and Change Date | Date Posted to Website* |
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| L8043               | Upper facial prosthesis, provided by a non-physician                                                                                              | Letter of medical necessity, including condition being treated.                                        | Durable Medical Equipment                | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001                                                                                     | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis                                                                                                                                                    | Added prior to 9/1/2019   |                         |
| L8044               | Hemi-facial prosthesis, provided by a non-physician                                                                                               | Letter of medical necessity, including condition being treated.                                        | Durable Medical Equipment                | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001                                                                                     | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis                                                                                                                                                    | Added prior to 9/1/2019   |                         |
| L8045               | Auricular prosthesis, provided by a non-physician                                                                                                 | Letter of medical necessity, including condition being treated.                                        | Durable Medical Equipment                | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001                                                                                     | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis                                                                                                                                                    | Added prior to 9/1/2019   |                         |
| L8046               | Partial facial prosthesis, provided by a nonphysician                                                                                             | Letter of medical necessity, including condition being treated.                                        | Durable Medical Equipment                | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001                                                                                     | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis                                                                                                                                                    | Added prior to 9/1/2019   |                         |
| L8047               | Nasal septal prosthesis, provided by a nonphysician                                                                                               | Letter of medical necessity, including condition being treated.                                        | Durable Medical Equipment                | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001                                                                                     | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis                                                                                                                                                    | Added prior to 9/1/2019   |                         |
| L8609               | Artificial cornea                                                                                                                                 | Letter of medical necessity, including condition being treated.                                        | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                         | SUR713.025<br>OTH903.030                                                                       | Intraocular Lens (IOLs) and Implantable Miniature Telescope (IMT)<br>Keratoprosthesis                                                                                                                                                                                           | Added prior to 9/1/2019   |                         |
| L8614               | COCHLEAR DEVICE, INCLUDES ALL INTERNAL AND EXTERNAL COMPONENTS                                                                                    | Pre-operative Evaluation, operative report, previous use of hearing aids, level of hearing Impairment. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                         | SUR714.004                                                                                     | Cochlear Implant                                                                                                                                                                                                                                                                | Added prior to 9/1/2019   |                         |
| L8619               | COCHLEAR IMPLANT, EXTERNAL SPEECH PROCESSOR AND CONTROLLER, INTEGRATED SYSTEM, REPLACEMENT                                                        | Pre-operative Evaluation, operative report, previous use of hearing aids, level of hearing Impairment. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                         | SUR714.004                                                                                     | Cochlear Implant                                                                                                                                                                                                                                                                | Added prior to 9/1/2019   |                         |
| L8627               | Cochlear implant, external speech processor, component, replacement                                                                               | Letter of medical necessity, including condition being treated.                                        | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                         | SUR714.004                                                                                     | Cochlear Implant                                                                                                                                                                                                                                                                | Added prior to 9/1/2019   |                         |
| L8628               | Cochlear implant, external controller component, replacement                                                                                      | Letter of medical necessity, including condition being treated.                                        | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                         | SUR714.004                                                                                     | Cochlear Implant                                                                                                                                                                                                                                                                | Added prior to 9/1/2019   |                         |
| L8629               | Transmitting coil and cable, integrated, for use with cochlear implant device, replacement                                                        | Letter of medical necessity, including condition being treated.                                        | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                         | SUR714.004                                                                                     | Cochlear Implant                                                                                                                                                                                                                                                                | Added prior to 9/1/2019   |                         |
| L8681               | Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only                             | Recent history and physical, plan of care, and documentation of medical necessity.                     | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                         | SUR712.033<br>MED205.036<br>SUR710.018<br>SUR712.021                                           | Occipital Nerve Stimulation<br>Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS)<br>Sacral Nerve Neuromodulation/Stimulation<br>Vagus Nerve Stimulation (VNS)                                                                                    | Added prior to 9/1/2019   |                         |
| L8682               | Implantable neurostimulator radiofrequency receiver                                                                                               | Recent history and physical, plan of care, and documentation of medical necessity.                     | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                         | SUR712.033<br>MED205.036<br>SUR712.021                                                         | Occipital Nerve Stimulation<br>Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS)<br>Vagus Nerve Stimulation (VNS)                                                                                                                                | Added prior to 9/1/2019   |                         |
| L8683               | Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver                                            | Recent history and physical, plan of care, and documentation of medical necessity.                     | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                         | SUR712.033<br>MED205.036<br>SUR712.021                                                         | Occipital Nerve Stimulation<br>Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS)<br>Vagus Nerve Stimulation (VNS)                                                                                                                                | Added prior to 9/1/2019   |                         |
| L8684               | Radiofrequency transmitter (external) for use with implantable sacral root neurostimulator receiver for bowel and bladder management, replacement | Recent history and physical, plan of care, and documentation of medical necessity.                     | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                         | SUR712.033                                                                                     | Occipital Nerve Stimulation                                                                                                                                                                                                                                                     | Added prior to 9/1/2019   |                         |
| L8685               | Implantable neurostimulator pulse generator, single array, rechargeable, includes extension                                                       | Recent history and physical, plan of care, and documentation of medical necessity.                     | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                         | SUR712.025<br>SUR709.031<br>SUR712.033<br>MED205.036<br>SUR710.018<br>SUR712.009<br>SUR712.021 | Deep Brain Stimulation (DBS)<br>Gastric Electrical Stimulation (GES)<br>Occipital Nerve Stimulation<br>Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS)<br>Sacral Nerve Neuromodulation/Stimulation<br>Spinal Cord Stimulation (SCS) and Dorsal | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code                                                                                                                                | Medical Records Request Information Required                                       | Clinical Criteria Category               | Clinical Criteria Hierarchy                                 | Medical Policy Number                                                                                        | Medical Policy Name                                                                                                                                                                                                                                                             | Effective and Change Date | Date Posted to Website* |
|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|------------------------------------------|-------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------|
| L8686               | Implantable neurostimulator pulse generator, single array, nonrechargeable, includes extension                                                               | Recent history and physical, plan of care, and documentation of medical necessity. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR712.025<br>SUR709.031<br>SUR712.033<br>MED205.036<br>SUR712.039<br>SUR710.018<br>SUR712.009<br>SUR712.021 | Deep Brain Stimulation (DBS)<br>Gastric Electrical Stimulation (GES)<br>Occipital Nerve Stimulation<br>Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS)<br>Responsive Neurostimulation (RNS) for the Treatment of Refractory Focal Epilepsy     | Added prior to 9/1/2019   |                         |
| L8687               | Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension                                                                    | Recent history and physical, plan of care, and documentation of medical necessity. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR712.025<br>SUR709.031<br>SUR712.033<br>MED205.036<br>SUR710.018<br>SUR712.009<br>SUR712.021               | Deep Brain Stimulation (DBS)<br>Gastric Electrical Stimulation (GES)<br>Occipital Nerve Stimulation<br>Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS)<br>Sacral Nerve Neuromodulation/Stimulation<br>Spinal Cord Stimulation (SCS) and Dorsal | Added prior to 9/1/2019   |                         |
| L8688               | Implantable neurostimulator pulse generator, dual array, nonrechargeable, includes extension                                                                 | Recent history and physical, plan of care, and documentation of medical necessity. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR712.025<br>SUR709.031<br>SUR712.033<br>MED205.036<br>SUR712.039<br>SUR710.018<br>SUR712.009<br>SUR712.021 | Deep Brain Stimulation (DBS)<br>Gastric Electrical Stimulation (GES)<br>Occipital Nerve Stimulation<br>Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS)<br>Responsive Neurostimulation (RNS) for the Treatment of Refractory Focal Epilepsy     | Added prior to 9/1/2019   |                         |
| L8689               | External recharging system for battery (internal) for use with implantable neurostimulator, replacement only                                                 | Recent history and physical, plan of care, and documentation of medical necessity. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR712.033<br>MED205.036<br>SUR712.021                                                                       | Occipital Nerve Stimulation<br>Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS)<br>Vagus Nerve Stimulation (VNS)                                                                                                                                | Added prior to 9/1/2019   |                         |
| L8690               | Auditory osseointegrated device, includes all internal and external components                                                                               | Recent history and physical, plan of care, and documentation of medical necessity. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR714.003                                                                                                   | Implantable Bone-Conduction and Bone-Anchored Hearing Aids                                                                                                                                                                                                                      | Added prior to 9/1/2019   |                         |
| L8691               | Auditory osseointegrated device, external sound processor, replacement                                                                                       | Recent history and physical, plan of care, and documentation of medical necessity. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR714.003                                                                                                   | Implantable Bone-Conduction and Bone-Anchored Hearing Aids                                                                                                                                                                                                                      | Added prior to 9/1/2019   |                         |
| L8692               | Auditory osseointegrated device, external sound processor, used without osseointegration, body worn, includes headband or other means of external attachment | Recent history and physical, plan of care, and documentation of medical necessity. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | DME104.001                                                                                                   | Upper-Limb Prosthesis, including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis                                                                                                                                                    | Added prior to 9/1/2019   |                         |
| M0076               | Prolotherapy                                                                                                                                                 | Recent history and physical, plan of care, and documentation of medical necessity. | Musculoskeletal                          | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | MED201.013                                                                                                   | Prolotherapy                                                                                                                                                                                                                                                                    | 1/1/2020                  |                         |
| Q0479               | Power module for use with electric or electric/pneumatic ventricular assist device, replacement only                                                         | Recent history and physical, plan of care, and documentation of medical necessity. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR707.017                                                                                                   | Ventricular Assist Devices and Total Artificial Hearts                                                                                                                                                                                                                          | Added prior to 9/1/2019   |                         |
| Q0480               | Driver for use with pneumatic ventricular assist device, replacement only                                                                                    | Recent history and physical, plan of care, and documentation of medical necessity. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR707.017                                                                                                   | Ventricular Assist Devices and Total Artificial Hearts                                                                                                                                                                                                                          | Added prior to 9/1/2019   |                         |
| Q0481               | Microprocessor control unit for use with electric ventricular assist device, replacement only                                                                | Recent history and physical, plan of care, and documentation of medical necessity. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR707.017                                                                                                   | Ventricular Assist Devices and Total Artificial Hearts                                                                                                                                                                                                                          | Added prior to 9/1/2019   |                         |
| Q0482               | Microprocessor control unit for use with electric/pneumatic combination ventricular assist device, replacement only                                          | Recent history and physical, plan of care, and documentation of medical necessity. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR707.017                                                                                                   | Ventricular Assist Devices and Total Artificial Hearts                                                                                                                                                                                                                          | Added prior to 9/1/2019   |                         |
| Q0483               | Monitor/display module for use with electric ventricular assist device, replacement only                                                                     | Recent history and physical, plan of care, and documentation of medical necessity. | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG | SUR707.017                                                                                                   | Ventricular Assist Devices and Total Artificial Hearts                                                                                                                                                                                                                          | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code                                                                                      | Medical Records Request Information Required                                                   | Clinical Criteria Category               | Clinical Criteria Hierarchy                                                                                                     | Medical Policy Number | Medical Policy Name                                    | Effective and Change Date | Date Posted to Website* |
|---------------------|--------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|-----------------------|--------------------------------------------------------|---------------------------|-------------------------|
| Q0484               | Monitor/display module for use with electric or electric/pneumatic ventricular assist device, replacement only     | Recent history and physical, plan of care, and documentation of medical necessity.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR707.017            | Ventricular Assist Devices and Total Artificial Hearts | Added prior to 9/1/2019   |                         |
| Q0489               | Power pack base for use with electric/pneumatic ventricular assist device, replacement only                        | Recent history and physical, plan of care, and documentation of medical necessity.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR707.017            | Ventricular Assist Devices and Total Artificial Hearts | Added prior to 9/1/2019   |                         |
| Q0495               | Battery/power pack charger for use with electric or electric/pneumatic ventricular assist device, replacement only | Recent history and physical, plan of care, and documentation of medical necessity.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR707.017            | Ventricular Assist Devices and Total Artificial Hearts | Added prior to 9/1/2019   |                         |
| Q0508               | MISCELLANEOUS SUPPLY OR ACCESSORY FOR USE WITH AN IMPLANTED VENTRICULAR ASSIST DEVICE                              | Recent history and physical, plan of care, and documentation of medical necessity.             | Medical Drug                             | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | SUR707.017            | Ventricular Assist Devices and Total Artificial Hearts | Added 1/1/23              |                         |
| Q2041               | Yescarta                                                                                                           | Recent history and physical, plan of care, and documentation of medical necessity.             | Medical Drug                             | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | RX502.061             | Oncology Medications                                   | 1/1/2022                  |                         |
| Q2042               | Kymriah                                                                                                            | Recent history and physical, plan of care, and documentation of medical necessity.             | Medical Drug                             | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | RX502.061             | Oncology Medications                                   | 1/1/2022                  |                         |
| Q2050               | Doxorubicin HCl Liposomal                                                                                          | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 | Medical Oncology                         | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon               | Carelon                                                | Change 8/1/2025           |                         |
| Q2053               | Tecartus                                                                                                           | Recent history and physical, plan of care, and documentation of medical necessity.             | Medical Drug                             | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | RX502.061             | Oncology Medications                                   | 11/20/2021                |                         |
| Q2054               | Usocabtagene Maraleucel                                                                                            | Recent history and physical, plan of care, and documentation of medical necessity.             | Medical Drug                             | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | RX502.061             | Oncology Medications                                   | 11/20/2021                |                         |
| Q4100               | Skin substitute, NOS                                                                                               | Recent history and physical, plan of care, and documentation of medical necessity.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR704.012            | Bioengineered Skin and Soft Tissue Substitutes         | Added 1/1/23              |                         |
| Q4101               | Apligraf skin sub                                                                                                  | Recent history and physical, plan of care, and documentation of medical necessity.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR704.012            | Bioengineered Skin and Soft Tissue Substitutes         | Added 1/1/23              |                         |
| Q4102               | Oasis wound matrix skin sub                                                                                        | Recent history and physical, plan of care, and documentation of medical necessity.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR704.012            | Bioengineered Skin and Soft Tissue Substitutes         | Added 1/1/23              |                         |
| Q4106               | Dermagraft skin sub                                                                                                | Recent history and physical, plan of care, and documentation of medical necessity.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR704.012            | Bioengineered Skin and Soft Tissue Substitutes         | Added 1/1/23              |                         |
| Q4107               | Graftjacket skin sub                                                                                               | Recent history and physical, plan of care, and documentation of medical necessity.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR704.012            | Bioengineered Skin and Soft Tissue Substitutes         | Added 1/1/23              |                         |
| Q4110               | Primatrix skin sub                                                                                                 | Recent history and physical, plan of care, and documentation of medical necessity.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR704.012            | Bioengineered Skin and Soft Tissue Substitutes         | Added 1/1/23              |                         |
| Q4116               | Skin Substitute, Alloderm, per square centimeter                                                                   | Recent history and physical, plan of care, and documentation of medical necessity.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR704.012            | Bioengineered Skin and Soft Tissue Substitutes         | Added 1/1/23              |                         |
| Q4121               | THERASKIN, PER SQUARE CENTIMETER                                                                                   | Recent history and physical, plan of care, and documentation of medical necessity.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR704.012            | Bioengineered Skin and Soft Tissue Substitutes         | Added 1/1/23              |                         |
| Q4131               | Epifix, per square centimeter (Human amniotic membrane allograft)                                                  | Recent history and physical, plan of care, and documentation of medical necessity.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR704.011            | Amniotic Membrane and Amniotic Fluid                   | Added prior to 9/1/2019   |                         |
| Q4132               | Grafix core, per square centimeter                                                                                 | Recent history and physical, plan of care, and documentation of medical necessity.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR704.011            | Amniotic Membrane and Amniotic Fluid                   | Added prior to 9/1/2019   |                         |
| Q4133               | Grafix prime, per square centimeter                                                                                | Recent history and physical, plan of care, and documentation of medical necessity.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR704.011            | Amniotic Membrane and Amniotic Fluid                   | Added prior to 9/1/2019   |                         |
| Q4159               | Affinity1 square cm                                                                                                | Recent history and physical, plan of care, and documentation of medical necessity.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR704.011            | Amniotic Membrane and Amniotic Fluid                   | Added 1/1/23              |                         |
| Q4160               | Nushield 1 square cm                                                                                               | Recent history and physical, plan of care, and documentation of medical necessity.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR704.011            | Amniotic Membrane and Amniotic Fluid                   | Added 1/1/23              |                         |
| Q4186               | EPIFIX PER SQUARE CENTIMETER                                                                                       | Recent history and physical, plan of care, and documentation of medical necessity.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR704.011            | Amniotic Membrane and Amniotic Fluid                   | Added 1/1/23              |                         |
| Q4187               | EPICORD PER SQUARE CENTIMETER                                                                                      | Recent history and physical, plan of care, and documentation of medical necessity.             | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR704.011            | Amniotic Membrane and Amniotic Fluid                   | Added 1/1/23              |                         |

| CPT and HCPCS Codes | Description of Procedure Code                                                                                                                     | Medical Records Request Information Required                                                                                                                                                                                                                                                 | Clinical Criteria Category               | Clinical Criteria Hierarchy                                                                                                     | Medical Policy Number    | Medical Policy Name                                                                          | Effective and Change Date | Date Posted to Website* |
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| Q4195               | PURAPLY PER SQUARE CENTIMETER                                                                                                                     | Recent history and physical, plan of care, and documentation of medical necessity.                                                                                                                                                                                                           | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR704.0132              | Bioengineered Skin and Soft Tissue Substitutes                                               | Added 1/1/23              |                         |
| Q4196               | PURAPLY AM PER SQUARE CENTIMETER                                                                                                                  | Recent history and physical, plan of care, and documentation of medical necessity.                                                                                                                                                                                                           | Outpatient Medical and surgical services | Illinois Medicaid Provider Manual, BCBS Medical Policy, MCG                                                                     | SUR704.0132              | Bioengineered Skin and Soft Tissue Substitutes                                               | Added 1/1/23              |                         |
| Q5101               | Zarxio                                                                                                                                            | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                                                                                                                                                                               | Medical Oncology                         | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                      | Change 8/1/2025           |                         |
| Q5103               | Q5103 Injection, infliximab-dyyb, biosimilar, 10 mg. New code effective 4/1/18 previously coded Q5102 which was deleted 3/31/18 Went live 11/1/17 | SRU                                                                                                                                                                                                                                                                                          | Specialty Pharmacy                       | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD guidelines                                             | RX501.051<br>ADM1001.034 | Infliximab and Associated Biosimilars Administration Site of Care Specialty Medication       | Added prior to 9/1/2019   |                         |
| Q5104               | 100 MG SOLR Q5104 Injection, infliximab-abda, biosimilar, 10 mg. New code effective 4/1/18 previously coded J3590, Go live 11/1/17                | SRU                                                                                                                                                                                                                                                                                          | Specialty Pharmacy                       | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD guidelines                                             | RX501.051<br>ADM1001.034 | Infliximab and Associated Biosimilars Administration Site of Care Specialty Medication       | Added prior to 9/1/2019   |                         |
| Q5106               | Anemia                                                                                                                                            | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 Carelon will review requests for oncology drugs that are supported by an oncology diagnosis. If the drug requested is not associated with an oncology diagnosis, it will be reviewed by BCBS. | Medical Oncology                         | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                      | 10/1/2025                 | 9/1/2025                |
| Q5106               | Anemia                                                                                                                                            | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity                                                                                                                                                                                   | Medical Drug                             | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX502.061<br>RX501.069   | <a href="#">Oncology Medications Erythropoiesis-Stimulating Agents (ESAs)</a>                | Added 11/1/2025           | 9/1/2025                |
| Q5107               | Bevacizumab-awwb                                                                                                                                  | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                                                                                                                                                                               | Medical Oncology                         | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                      | Change 8/1/2025           |                         |
| Q5108               | Pegfilgrastim-jmdb                                                                                                                                | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                                                                                                                                                                               | Medical Oncology                         | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                      | Change 8/1/2025           |                         |
| Q5110               | Nivestym                                                                                                                                          | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                                                                                                                                                                               | Medical Oncology                         | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                      | Change 8/1/2025           |                         |
| Q5111               | Pegfilgrastim-cbqv                                                                                                                                | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                                                                                                                                                                               | Medical Oncology                         | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                      | Change 8/1/2025           |                         |
| Q5112               | Trastuzumab-dttb                                                                                                                                  | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                                                                                                                                                                               | Medical Oncology                         | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                      | Change 8/1/2025           |                         |
| Q5113               | Trastuzumab-pkrb                                                                                                                                  | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                                                                                                                                                                               | Medical Oncology                         | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                      | Change 8/1/2025           |                         |
| Q5114               | Trastuzumab-dkst                                                                                                                                  | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                                                                                                                                                                               | Medical Oncology                         | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                      | Change 8/1/2025           |                         |
| Q5115               | Truxima                                                                                                                                           | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 Carelon will review requests for oncology drugs that are supported by an oncology diagnosis. If the drug requested is not associated with an oncology diagnosis, it will be reviewed by BCBS. | Medical Oncology                         | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                      | 10/1/2025                 | 9/1/2025                |
| Q5115               | Truxima                                                                                                                                           | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity                                                                                                                                                                                   | Medical Drug                             | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX502.061<br>RX502.030   | <a href="#">Oncology Medications Rituximab and Biosimilars for Non-Oncologic Indications</a> | Added 11/1/2025           | 9/1/2025                |
| Q5116               | Trastuzumab-qyyp                                                                                                                                  | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                                                                                                                                                                               | Medical Oncology                         | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                      | Change 8/1/2025           |                         |
| Q5117               | Trastuzumab-anns                                                                                                                                  | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                                                                                                                                                                               | Medical Oncology                         | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                      | Change 8/1/2025           |                         |
| Q5118               | Injection, bevacizumab-bvzr, biosimilar, (zirabev), 10 mg                                                                                         | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                                                                                                                                                                               | Medical Oncology                         | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                      | Change 8/1/2025           |                         |
| Q5119               | Ruxience                                                                                                                                          | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 Carelon will review requests for oncology drugs that are supported by an oncology diagnosis. If the drug requested is not associated with an oncology diagnosis, it will be reviewed by BCBS. | Medical Oncology                         | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                      | 10/1/2025                 | 9/1/2025                |
| Q5119               | Ruxience                                                                                                                                          | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity                                                                                                                                                                                   | Medical Drug                             | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX502.061<br>RX502.030   | <a href="#">Oncology Medications Rituximab and Biosimilars for Non-Oncologic Indications</a> | Added 11/1/2025           | 9/1/2025                |

| CPT and HCPCS Codes | Description of Procedure Code                                                     | Medical Records Request Information Required                                                                                                                                                                                                                                                 | Clinical Criteria Category | Clinical Criteria Hierarchy                                                                                                     | Medical Policy Number    | Medical Policy Name                                                                                    | Effective and Change Date | Date Posted to Website* |
|---------------------|-----------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|---------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------------------------------------------|---------------------------|-------------------------|
| Q5120               | Pegfilgrastim-bmez                                                                | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                                                                                                                                                                               | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                                | Change 8/1/2025           |                         |
| Q5121               | Injection; Immunomodulators                                                       | SRU                                                                                                                                                                                                                                                                                          | Specialty Pharmacy         | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.051<br>ADM1001.034 | Infliximab and Associated Biosimilars Specialty Medication Administration Site of Care Acne Management | 4/1/2021                  |                         |
| Q5122               | Pegfilgrastim-apgf                                                                | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                                                                                                                                                                               | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                                | Change 8/1/2025           |                         |
| Q5123               | rituximab-arxx non-oncology                                                       | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415 Carelon will review requests for oncology drugs that are supported by an oncology diagnosis. If the drug requested is not associated with an oncology diagnosis, it will be reviewed by BCBS. | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                                | 10/1/2025                 | 9/1/2025                |
| Q5123               | rituximab-arxx non-oncology                                                       | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity                                                                                                                                                                                   | Medical Drug               | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX502.061<br>RX502.030   | Oncology Medications Rituximab and Biosimilars for Non-Oncologic Indications                           | Added 11/1/2025           | 9/1/2025                |
| Q5125               | Riabni                                                                            | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                                                                                                                                                                               | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                                | Change 8/1/2025           |                         |
| Q5126               | Bevacizumab-maly                                                                  | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                                                                                                                                                                               | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                                | Change 8/1/2025           |                         |
| Q5127               | Pegfilgrastim-fpgk                                                                | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                                                                                                                                                                               | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                                | Change 8/1/2025           |                         |
| Q5128               | Injection, ranibizumab-eqrn (cimerli), biosimilar, 0.1 mg                         | Recent history and physical, plan of care, and documentation of medical necessity.                                                                                                                                                                                                           | Medical Drug               | BCBS Medical Policy Illinois Medicaid Provider Manual, Medicare NCD/LCD Guidelines                                              | OTH903.041               | Ranibizumab Injections, Implants and Biosimilars                                                       | Change 11/1/2025          | 9/1/2025                |
| Q5129               | Bevacizumab-adcd                                                                  | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                                                                                                                                                                               | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                                | Change 8/1/2025           |                         |
| Q5130               | Pegfilgrastim-pbbk                                                                | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                                                                                                                                                                               | Medical Oncology           | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                                | Change 8/1/2025           |                         |
| Q5133               | Tofidence                                                                         | Recent history and physical, plan of care, and documentation of medical necessity.                                                                                                                                                                                                           | Medical Drug               | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines                                             | RX501.115                | Tocilizumab and Associated Biosimilar(s)                                                               | 1/1/2025                  |                         |
| S0013               | Spravato                                                                          | SRU                                                                                                                                                                                                                                                                                          | Specialty Pharmacy         | eviCore - 1-855-252-1117 or <a href="https://www.evicore.com/healthplan/bcbs">https://www.evicore.com/healthplan/bcbs</a>       | RX501.105                | Esketamine Nasal Spray                                                                                 | 10/1/2021                 |                         |
| S2118               | Metal-on-metal total hip resurfacing, including acetabular and femoral components | Carelon- <a href="https://providerportal.com/">https://providerportal.com/</a> or 866-455-8415                                                                                                                                                                                               | Musculoskeletal            | <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/">https://guidelines.carelonmedicalbenefitsmanagement.com/</a> | Carelon                  | Carelon                                                                                                | Change 8/1/2025           |                         |
| S5100               | Adult Day Service LTSS                                                            | 15 minutes = 1 unit                                                                                                                                                                                                                                                                          | LTSS                       | Illinois Administrative Code                                                                                                    | No Med Policy            | No Med Policy                                                                                          | Added prior to 9/1/2019   |                         |
| S5125               | *Personal Care Assistant LTSS                                                     | 15 minutes = 1 unit                                                                                                                                                                                                                                                                          | LTSS                       | Illinois Administrative Code                                                                                                    | No Med Policy            | No Med Policy                                                                                          | Added prior to 9/1/2019   |                         |
| S5126               | *Personal Care Assistant LTSS                                                     | 15 minutes = 1 unit                                                                                                                                                                                                                                                                          | LTSS                       | Illinois Administrative Code                                                                                                    | No Med Policy            | No Med Policy                                                                                          | Added prior to 9/1/2019   |                         |
| S5130               | Homemaker/Housekeeper Services LTSS                                               | 15 minutes = 1 unit                                                                                                                                                                                                                                                                          | LTSS                       | Illinois Administrative Code                                                                                                    | No Med Policy            | No Med Policy                                                                                          | Added prior to 9/1/2019   |                         |
| S5160               | Electronic Home Response - Installation                                           | 1/Lifetime                                                                                                                                                                                                                                                                                   | LTSS                       | Illinois Administrative Code                                                                                                    | No Med Policy            | No Med Policy                                                                                          | Added prior to 9/1/2019   |                         |
| S5161               | Electronic Home Response - Monthly Rent                                           | 1/Month                                                                                                                                                                                                                                                                                      | LTSS                       | Illinois Administrative Code                                                                                                    | No Med Policy            | No Med Policy                                                                                          | Added prior to 9/1/2019   |                         |
| S5165               | Environmental Accessibility Adaptations - Home LTSS                               | Services are limited to service cost/plan maximum according to member's need. Services limited to \$25,000 within a 5 year period.                                                                                                                                                           | LTSS                       | Illinois Administrative Code                                                                                                    | DME101.010               | Wheelchairs and Accessories                                                                            | Added prior to 9/1/2019   |                         |
| S5170               | Home Delivered Meals LTSS                                                         | 2 meals per day and up to 7 days a week (2 meals = 1 unit; Time Period = month)                                                                                                                                                                                                              | LTSS                       | Illinois Administrative Code                                                                                                    | No Med Policy            | No Med Policy                                                                                          | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code                                                                                                                                                                                                                                   | Medical Records Request Information Required                                       | Clinical Criteria Category | Clinical Criteria Hierarchy                                                         | Medical Policy Number | Medical Policy Name | Effective and Change Date | Date Posted to Website* |
|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|----------------------------|-------------------------------------------------------------------------------------|-----------------------|---------------------|---------------------------|-------------------------|
| S5501               | Home infusion therapy, catheter care / maintenance, complex (more than one lumen), includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), p | Recent history and physical, plan of care, and documentation of medical necessity. | Home Health                | Illinois Medicaid Provider Manual, MCG, Medicare NCD/LCD Guidelines                 | No Med Policy         | No Med Policy       | Added prior to 9/1/2019   |                         |
| S9123               | Nursing care in the home, by RN, per hour (use for general nursing care only, not to be used when cpt codes 99500-99602 can be used).                                                                                                                           | Recent history and physical, plan of care, and documentation of medical necessity. | Home Health                | Illinois Medicaid Provider Manual, MCG, Medicare NCD/LCD Guidelines                 | No Med Policy         | No Med Policy       | Added prior to 9/1/2019   |                         |
| S9341               | Home therapy; enteral nutrition via gravity; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula and nursing visits coded separately) per diem                                | Recent history and physical, plan of care, and documentation of medical necessity. | Home Health                | Illinois Medicaid Provider Manual, MCG, Medicare NCD/LCD Guidelines, Medical Policy | MED201.011            | Nutritional Support | Added prior to 9/1/2019   |                         |
| S9342               | Home therapy; enteral nutrition via pump; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula and nursing visits coded separately) per diem                                   | Recent history and physical, plan of care, and documentation of medical necessity. | Home Health                | Illinois Medicaid Provider Manual, MCG, Medicare NCD/LCD Guidelines, Medical Policy | MED201.011            | Nutritional Support | Added prior to 9/1/2019   |                         |
| S9343               | Home therapy; enteral nutrition via bolus; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula and nursing visits coded separately) per diem                                  | Recent history and physical, plan of care, and documentation of medical necessity. | Home Health                | Illinois Medicaid Provider Manual, MCG, Medicare NCD/LCD Guidelines, Medical Policy | MED201.011            | Nutritional Support | Added prior to 9/1/2019   |                         |
| S9366               | Home infusion therapy, total parenteral nutrition (tpn); more than one liter but no more than two liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard tpn   | Recent history and physical, plan of care, and documentation of medical necessity. | Home Health                | Illinois Medicaid Provider Manual, MCG, Medicare NCD/LCD Guidelines, Medical Policy | MED201.011            | Nutritional Support | Added prior to 9/1/2019   |                         |
| S9494               | Home infusion therapy, antibiotic, antiviral, or antifungal therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem                 | Recent history and physical, plan of care, and documentation of medical necessity. | Home Health                | Illinois Medicaid Provider Manual, MCG, Medicare NCD/LCD Guidelines                 | No Med Policy         | No Med Policy       | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes      | Description of Procedure Code                                                                                                                                                                                                                                   | Medical Records Request Information Required                                       | Clinical Criteria Category | Clinical Criteria Hierarchy                                                         | Medical Policy Number | Medical Policy Name                                                                                                          | Effective and Change Date | Date Posted to Website* |
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| S9501                    | Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 12 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per | Recent history and physical, plan of care, and documentation of medical necessity. | Home Health                | Illinois Medicaid Provider Manual, MCG, Medicare NCD/LCD Guidelines                 | No Med Policy         | No Med Policy                                                                                                                | Added prior to 9/1/2019   |                         |
| T1002                    | RN services up to 15 minutes                                                                                                                                                                                                                                    | 15 minutes = 1 unit                                                                | LTSS                       | Illinois Administrative Code                                                        | No Med Policy         | No Med Policy                                                                                                                | 7/1/2025                  |                         |
| T1003                    | LPN/LVN services up to 15 minutes                                                                                                                                                                                                                               | 15 minutes = 1 unit                                                                | LTSS                       | Illinois Administrative Code                                                        | No Med Policy         | No Med Policy                                                                                                                | 7/1/2025                  |                         |
| T1004                    | Nsg Aide service up to 15 minutes                                                                                                                                                                                                                               | 15 minutes = 1 unit                                                                | LTSS                       | Illinois Administrative Code                                                        | No Med Policy         | No Med Policy                                                                                                                | 7/1/2025                  |                         |
| T1005                    | Respite - Homemaker LTSS                                                                                                                                                                                                                                        | Recent history and physical, plan of care, and documentation of medical necessity. | LTSS                       | Illinois Administrative Code                                                        | No Med Policy         | No Med Policy                                                                                                                | Added prior to 9/1/2019   |                         |
| T1005*                   | Respite - Personal Assistant LTSS                                                                                                                                                                                                                               | Available for waivers except Elderly.                                              | LTSS                       | Illinois Administrative Code                                                        | No Med Policy         | No Med Policy                                                                                                                | Added prior to 9/1/2019   |                         |
| T1019                    | *Personal Care Assistant LTSS                                                                                                                                                                                                                                   | 15 minutes = 1 unit                                                                | LTSS                       | Illinois Administrative Code                                                        | No Med Policy         | No Med Policy                                                                                                                | Added prior to 9/1/2019   |                         |
| T1020                    | *Personal Care Assistant LTSS                                                                                                                                                                                                                                   | 15 minutes = 1 unit                                                                | LTSS                       | Illinois Administrative Code                                                        | No Med Policy         | No Med Policy                                                                                                                | Added prior to 9/1/2019   |                         |
| T1505                    | Elec med comp dev, noc                                                                                                                                                                                                                                          |                                                                                    | LTSS                       | Illinois Administrative Code                                                        | No Med Policy         | No Med Policy                                                                                                                | 7/1/2025                  |                         |
| T2003                    | Adult Day Service Transportation LTSS                                                                                                                                                                                                                           | Max of 2 visits per day. 1 way=1unit                                               | LTSS                       | Illinois Administrative Code                                                        | No Med Policy         | No Med Policy                                                                                                                | Added prior to 9/1/2019   |                         |
| T2014                    | Pre-vocational Services LTSS                                                                                                                                                                                                                                    | Brain injury waiver only. Per diam                                                 | LTSS                       | Illinois Administrative Code                                                        | No Med Policy         | No Med Policy                                                                                                                | Added prior to 9/1/2019   |                         |
| T2019                    | Supported Employment LTSS                                                                                                                                                                                                                                       | Brain injury waiver only.                                                          | LTSS                       | Illinois Administrative Code                                                        | No Med Policy         | No Med Policy                                                                                                                | Added prior to 9/1/2019   |                         |
| T2020                    | Habitation - Day LTSS                                                                                                                                                                                                                                           | Brain injury waiver only.                                                          | LTSS                       | Illinois Administrative Code                                                        | PSY301.021            | Applied Behavior Analysis (ABA) for Autism Spectrum Disorder (ASD) Diagnosis                                                 | Added prior to 9/1/2019   |                         |
| T2028                    | Special supply, nos waiver                                                                                                                                                                                                                                      |                                                                                    | LTSS                       | Illinois Administrative Code                                                        | No Med Policy         | No Med Policy                                                                                                                | 7/1/2025                  |                         |
| T2101                    | Human Breast Milk                                                                                                                                                                                                                                               | Recent history and physical, plan of care, and documentation of medical necessity. | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | MED201.011            | Nutritional Support                                                                                                          | 1/1/2021                  |                         |
| V5298                    | Hearing aid, not otherwise classified                                                                                                                                                                                                                           | Letter of medical necessity, including condition being treated.                    | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| V5299                    | Hearing service, miscellaneous                                                                                                                                                                                                                                  | Letter of medical necessity, including condition being treated.                    | Durable Medical Equipment  | Illinois Medicaid Provider Manual, BCBS Medical Policy, Medicare NCD/LCD Guidelines | DME104.001            | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | Added prior to 9/1/2019   |                         |
| <b>Behavioral Health</b> |                                                                                                                                                                                                                                                                 |                                                                                    |                            |                                                                                     |                       |                                                                                                                              |                           |                         |
| H2036                    | Substance Abuse Adolescent Residential                                                                                                                                                                                                                          | Documentation of medical necessity for ASAM Dimensions 1-6 Criteria                | Behavioral Health          | American Society of Addiction Medicine (ASAM)                                       |                       |                                                                                                                              | Added prior to 9/1/2019   |                         |
| H0004 TF                 | Behavioral health counseling and therapy                                                                                                                                                                                                                        | Documentation of medical necessity for ASAM Dimensions 1-6 Criteria                | Behavioral Health          | American Society of Addiction Medicine (ASAM)                                       |                       |                                                                                                                              | 1/1/2025                  |                         |
| H0005 TF                 | Behavioral health counseling and therapy                                                                                                                                                                                                                        | Documentation of medical necessity for ASAM Dimensions 1-6 Criteria                | Behavioral Health          | American Society of Addiction Medicine (ASAM)                                       |                       |                                                                                                                              | 1/1/2025                  |                         |
| H0047                    | Substance Abuse Rehabilitation                                                                                                                                                                                                                                  | Documentation of medical necessity for ASAM Dimensions 1-6 Criteria                | Behavioral Health          | American Society of Addiction Medicine (ASAM)                                       |                       |                                                                                                                              | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes | Description of Procedure Code                                           | Medical Records Request Information Required                                                                                                                                                                                                     | Clinical Criteria Category | Clinical Criteria Hierarchy                              | Medical Policy Number | Medical Policy Name                                                                   | Effective and Change Date | Date Posted to Website* |
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| H0010               | Substance Acute Abuse Detoxification                                    | Documentation of medical necessity for ASAM Dimensions 1-6 Criteria                                                                                                                                                                              | Behavioral Health          | American Society of Addiction Medicine (ASAM)            |                       |                                                                                       | Added prior to 9/1/2019   |                         |
| S9480               | Mental Health Intensive Outpatient Services                             | Documentation of medical necessity                                                                                                                                                                                                               | Behavioral Health          | MCG Care Guidelines                                      |                       |                                                                                       | Added prior to 9/1/2019   |                         |
| H0039               | Assertive Community Treatment                                           | For Illinois Medicaid Service Request, please complete and submit Rule 132 Authorization Form.<br><a href="https://www.bcbsil.com/provider/education/forms.html">https://www.bcbsil.com/provider/education/forms.html</a><br><br>1 unit=15 min   | Behavioral Health          | IDHS Mental Health Medical Necessity and Guidance Manual |                       |                                                                                       | Added prior to 9/1/2019   |                         |
| H2016               | Community Support Team                                                  | For Illinois Medicaid Service Request, please complete and submit Rule 132 Authorization Form.<br><a href="https://www.bcbsil.com/provider/education/forms.html">https://www.bcbsil.com/provider/education/forms.html</a><br><br>1 unit=15 min   | Behavioral Health          | IDHS Mental Health Medical Necessity and Guidance Manual |                       |                                                                                       | Added prior to 9/1/2019   |                         |
| H2017               | Psychosocial Rehabilitation                                             | For Illinois Medicaid Service Request, please complete and submit Rule 132 Authorization Form.<br><a href="https://www.bcbsil.com/provider/education/forms.html">https://www.bcbsil.com/provider/education/forms.html</a><br><br>1 unit = 15 min | Behavioral Health          | IDHS Mental Health Medical Necessity and Guidance Manual |                       |                                                                                       | Added prior to 9/1/2019   |                         |
| T1005               | Respite, Individual/Group                                               | Documentation of medical necessity                                                                                                                                                                                                               | Behavioral Health          | IDHS Mental Health Medical Necessity and Guidance Manual |                       |                                                                                       |                           |                         |
| 90867               | Transcranial Magnetic Stimulation ***Service Only Available for MMAI*** | Documentation of medical necessity<br>**Service Only Available for MMAI**                                                                                                                                                                        | Behavioral Health          | LCD/BCBS Medical Policy                                  | PSY301.015            | Transcranial Magnetic Stimulation as a Treatment for Psychiatric/Neurologic Disorders | Added prior to 9/1/2019   |                         |
| 90868               | Transcranial Magnetic Stimulation ***Service Only Available for MMAI*** | Documentation of medical necessity<br>**Service Only Available for MMAI**                                                                                                                                                                        | Behavioral Health          | LCD/BCBS Medical Policy                                  | PSY301.015            | Transcranial Magnetic Stimulation as a Treatment for Psychiatric/Neurologic Disorders | Added prior to 9/1/2019   |                         |
| 97151               | Behavior Identification Assessment                                      | Documentation of medical necessity; please complete the ABA Initial Assessment Request form                                                                                                                                                      | Behavioral Health          | BCBS Medical Policy                                      | PSY301.021            | Applied Behavior Analysis (ABA) for Autism Spectrum Disorder (ASD) Diagnosis          | Added prior to 9/1/2019   |                         |
| 97152               | Behavior Identification Supporting Assessment                           | Documentation of medical necessity; please complete the ABA Initial Assessment Request form                                                                                                                                                      | Behavioral Health          | BCBS Medical Policy                                      | PSY301.021            | Applied Behavior Analysis (ABA) for Autism Spectrum Disorder (ASD) Diagnosis          | Added prior to 9/1/2019   |                         |
| 97153               | Adaptive Behavior Treatment by Protocol                                 | Documentation of medical necessity; please complete the ABA Clinical Service Request form                                                                                                                                                        | Behavioral Health          | BCBS Medical Policy                                      | PSY301.021            | Applied Behavior Analysis (ABA) for Autism Spectrum Disorder (ASD) Diagnosis          | Added prior to 9/1/2019   |                         |
| 97154               | Group Adaptive Behavior Treatment by Protocol                           | Documentation of medical necessity; please complete the ABA Clinical Service Request form                                                                                                                                                        | Behavioral Health          | BCBS Medical Policy                                      | PSY301.021            | Applied Behavior Analysis (ABA) for Autism Spectrum Disorder (ASD) Diagnosis          | Added prior to 9/1/2019   |                         |
| 97155               | Adaptive Behavior Treatment with Protocol Modification                  | Documentation of medical necessity; please complete the ABA Clinical Service Request form                                                                                                                                                        | Behavioral Health          | BCBS Medical Policy                                      | PSY301.021            | Applied Behavior Analysis (ABA) for Autism Spectrum Disorder (ASD) Diagnosis          | Added prior to 9/1/2019   |                         |
| 97156               | Family Adaptive Behavior Treatment Guidance                             | Documentation of medical necessity; please complete the ABA Clinical Service Request form                                                                                                                                                        | Behavioral Health          | BCBS Medical Policy                                      | PSY301.021            | Applied Behavior Analysis (ABA) for Autism Spectrum Disorder (ASD) Diagnosis          | Added prior to 9/1/2019   |                         |
| 97157               | Multiple Family Group Adaptive Behavior Treatment Guidance              | Documentation of medical necessity; please complete the ABA Clinical Service Request form                                                                                                                                                        | Behavioral Health          | BCBS Medical Policy                                      | PSY301.021            | Applied Behavior Analysis (ABA) for Autism Spectrum Disorder (ASD) Diagnosis          | Added prior to 9/1/2019   |                         |
| 97158               | Group Adaptive Behavior Treatment with Protocol Modification            | Documentation of medical necessity; please complete the ABA Clinical Service Request form                                                                                                                                                        | Behavioral Health          | BCBS Medical Policy                                      | PSY301.021            | Applied Behavior Analysis (ABA) for Autism Spectrum Disorder (ASD) Diagnosis          | Added prior to 9/1/2019   |                         |
| 0362T               | Behavior Identification Supporting Assessment                           | Documentation of medical necessity                                                                                                                                                                                                               | Behavioral Health          | BCBS Medical Policy                                      | PSY301.021            | Applied Behavior Analysis (ABA) for Autism Spectrum Disorder (ASD) Diagnosis          | Added prior to 9/1/2019   |                         |
| 0373T               | Adaptive Behavior Treatment with Protocol Modification                  | Documentation of medical necessity                                                                                                                                                                                                               | Behavioral Health          | BCBS Medical Policy                                      | PSY301.021            | Applied Behavior Analysis (ABA) for Autism Spectrum Disorder (ASD) Diagnosis          | Added prior to 9/1/2019   |                         |

| CPT and HCPCS Codes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Description of Procedure Code | Medical Records Request Information Required | Clinical Criteria Category | Clinical Criteria Hierarchy | Medical Policy Number | Medical Policy Name | Effective and Change Date | Date Posted to Website* |
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