# Marketplace Prior Auth (PA) Code Matrix Effective Q1, 2026

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

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

**This Matrix is for Outpatient services.**

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

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

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

| Code | Description | Service Category | MHI PA Required? | Evolent PA Required? | MHI Code Notes | Evolent CT 1/1/26 Oncology |
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| 80307 | DRUG TEST PRSMV INSTRMNT CHEM ANALYZERS PR DATE | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | PA required after 24 units per calendar year. | |
| 90867 | THRPTC RPTTV TMS TX INTL W MAP MOTR THRESHLD DLVRY AND MNGMNT | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | For services rendered by a Behavioral Health Provider, contact OptumHealth Behavioral Solutions (OHBS). Contact Molina if services are rendered by a Medical Healthcare Provider. | |
| 90868 | THERAP REPETITIVE TMS TX SUBSEQ DELIVERY AND MNG | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | For services rendered by a Behavioral Health Provider, contact OptumHealth Behavioral Solutions (OHBS). Contact Molina if services are rendered by a Medical Healthcare Provider. | |
| 90869 | REPET TMS TX SUBSEQ MOTR THRESHLD W DLVRY AND MNGMNT | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | For services rendered by a Behavioral Health Provider, contact OptumHealth Behavioral Solutions (OHBS). Contact Molina if services are rendered by a Medical Healthcare Provider. | |
| 90875 | INDIV PSYCHOPHYS BIOFEED TRAIN W/PSYTX 30 MIN | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | For services rendered by a Behavioral Health Provider, contact OptumHealth Behavioral Solutions (OHBS). Contact Molina if services are rendered by a Medical Healthcare Provider. | |
| 90876 | INDIV PSYCHOPHYS BIOFEED TRAIN W/PSYTX 45 MIN | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | For services rendered by a Behavioral Health Provider, contact OptumHealth Behavioral Solutions (OHBS). Contact Molina if services are rendered by a Medical Healthcare Provider. | |
| 90901 | BIOFEEDBACK TRAINING ANY MODALITY | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | For services rendered by a Behavioral Health Provider, contact OptumHealth Behavioral Solutions (OHBS). Contact Molina if services are rendered by a Medical Healthcare Provider. | |
| 90912 | BFB TRAING W/EMG AND /MANOMETRY 1ST 15 MIN CNTCT | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | For services rendered by a Behavioral Health Provider, contact OptumHealth Behavioral Solutions (OHBS). Contact Molina if services are rendered by a Medical Healthcare Provider. | |
| 90913 | BFB TRAING W/EMG AND /MANOMETRY EA ADDL 15 MIN CNTCT | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | For services rendered by a Behavioral Health Provider, contact OptumHealth Behavioral Solutions (OHBS). Contact Molina if services are rendered by a Medical Healthcare Provider. | |
| 96020 | TEST SELECT AND ADMN FUNCTL BRAIN MAP PHYS/QHP | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | For services rendered by a Behavioral Health Provider, contact OptumHealth Behavioral Solutions (OHBS). Contact Molina if services are rendered by a Medical Healthcare Provider. | |

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| 97153 | ADAPTIVE BEHAVIOR TX BY PROTOCOL TECH EA 15 MIN | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | For services rendered by a Behavioral Health Provider, contact OptumHealth Behavioral Solutions (OHBS). Contact Molina if services are rendered by a Medical Healthcare Provider. | |
| 97154 | GROUP ADAPTIVE BHV TX BY PROTOCOL TECH EA 15 MIN | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | For services rendered by a Behavioral Health Provider, contact OptumHealth Behavioral Solutions (OHBS). Contact Molina if services are rendered by a Medical Healthcare Provider. | |
| 97155 | ADAPT BHV TX PRTCL MODIFICAJ PHYS QHP EA 15 MIN | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | For services rendered by a Behavioral Health Provider, contact OptumHealth Behavioral Solutions (OHBS). Contact Molina if services are rendered by a Medical Healthcare Provider. | |
| 97156 | FAMILY ADAPT BHV TX GDN PHYS QHP EA 15 MIN | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | For services rendered by a Behavioral Health Provider, contact OptumHealth Behavioral Solutions (OHBS). Contact Molina if services are rendered by a Medical Healthcare Provider. | |
| 97157 | MULTIPLE FAM GROUP BHV TX GDN PHYS QHP EA 15 MIN | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | For services rendered by a Behavioral Health Provider, contact OptumHealth Behavioral Solutions (OHBS). Contact Molina if services are rendered by a Medical Healthcare Provider. | |
| 97158 | GRP ADAPT BHV PRTCL MODIFCAN PHYS QHP EA 15 MIN | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | For services rendered by a Behavioral Health Provider, contact OptumHealth Behavioral Solutions (OHBS). Contact Molina if services are rendered by a Medical Healthcare Provider. | |
| 0373T | ADAPT BHV TX PRTCL MODIFICAJ EA 15 MIN TECH TIME | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | For services rendered by a Behavioral Health Provider, contact OptumHealth Behavioral Solutions (OHBS). Contact Molina if services are rendered by a Medical Healthcare Provider. | |
| G0480 | DRUG TEST DEF 1-7 DRUG CLASSES | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | DEFINITIVE - PA after 12 dates of service for codes G0480, G0481, G0482, G0483, G0659 | |
| G0481 | DRUG TEST DEF 8-14 DRUG CLASSES | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | DEFINITIVE - PA after 12 dates of service for codes G0480, G0481, G0482, G0483, G0659 | |
| G0482 | DRUG TEST DEF 15-21 DRUG CLASSES | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | DEFINITIVE - PA after 12 dates of service for codes G0480, G0481, G0482, G0483, G0659 | |
| G0483 | DRUG TEST DEF 22 OR MORE DRUG CLASSES | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | DEFINITIVE - PA after 12 dates of service for codes G0480, G0481, G0482, G0483, G0659 | |
| G0659 | DRUG TEST DEF SIMPLE ALL CL | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | DEFINITIVE - PA after 12 dates of service for codes G0480, G0481, G0482, G0483, G0659 | |
| H0008 | ALCOHOL AND OR DRUG SRVC; SUB-ACUTE DTOX HOSP IP | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | For services rendered by a Behavioral Health Provider, contact OptumHealth Behavioral Solutions (OHBS). Contact Molina if services are rendered by a Medical Healthcare Provider. | |
| H0009 | ALCOHOL AND OR DRUG SERVICES; ACUTE DTOX HOSP IP | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | For services rendered by a Behavioral Health Provider, contact OptumHealth Behavioral Solutions (OHBS). Contact Molina if services are rendered by a Medical Healthcare Provider. | |
| H0010 | ALCOHOL AND / DRUG SRVC; SUB-ACUTE DTOX RES PROG IP | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | For services rendered by a Behavioral Health Provider, contact OptumHealth Behavioral Solutions (OHBS). Contact Molina if services are rendered by a Medical Healthcare Provider. | |
| H0011 | ALCOHOL AND / DRUG SERVICES; ACUTE DTOX RES PROG IP | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | For services rendered by a Behavioral Health Provider, contact OptumHealth Behavioral Solutions (OHBS). Contact Molina if services are rendered by a Medical Healthcare Provider. | |
| H0012 | ALCOHOL AND DRUG SRVC; SUB-ACUTE DTOX RES PROG OP | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | For services rendered by a Behavioral Health Provider, contact OptumHealth Behavioral Solutions (OHBS). Contact Molina if services are rendered by a Medical Healthcare Provider. | |
| H0013 | ALCOHOL AND DRUG SERVICES; ACUTE DTOX RES PROG OP | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | For services rendered by a Behavioral Health Provider, contact OptumHealth Behavioral Solutions (OHBS). Contact Molina if services are rendered by a Medical Healthcare Provider. | |

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| H0014 | ALCOHOL AND OR DRUG SERVICES; AMB DETOXIFICATION | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | For services rendered by a Behavioral Health Provider, contact OptumHealth Behavioral Solutions (OHBS). Contact Molina if services are rendered by a Medical Healthcare Provider. | |
| H0015 | ALCOHOL AND/OR DRUG SRVCS | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | For services rendered by a Behavioral Health Provider, contact OptumHealth Behavioral Solutions (OHBS). Contact Molina if services are rendered by a Medical Healthcare Provider. | |
| H0016 | ALCOHOL AND OR DRUG SERVICES; MEDICAL SOMATIC | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | For services rendered by a Behavioral Health Provider, contact OptumHealth Behavioral Solutions (OHBS). Contact Molina if services are rendered by a Medical Healthcare Provider. | |
| H0017 | BEHAVIORAL HEALTH; RES W O ROOM AND BOARD PER DIEM | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | For services rendered by a Behavioral Health Provider, contact OptumHealth Behavioral Solutions (OHBS). Contact Molina if services are rendered by a Medical Healthcare Provider. | |
| H0018 | BHVAL HEALTH; SHORT-TERM RES W O ROOM AND BOARD-DIEM | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | For services rendered by a Behavioral Health Provider, contact OptumHealth Behavioral Solutions (OHBS). Contact Molina if services are rendered by a Medical Healthcare Provider. | |
| H0035 | MENTAL HEALTH PARTIAL HOSP TX UNDER 24 HOURS | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | For services rendered by a Behavioral Health Provider, contact OptumHealth Behavioral Solutions (OHBS). Contact Molina if services are rendered by a Medical Healthcare Provider. | |
| H0040 | ASSERT COMM TX PROG - PER DIEM | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | For services rendered by a Behavioral Health Provider, contact OptumHealth Behavioral Solutions (OHBS). Contact Molina if services are rendered by a Medical Healthcare Provider. | |
| H0046 | MENTAL HEALTH SERVICES NOT OTHERWISE SPECIFIED | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | For services rendered by a Behavioral Health Provider, contact OptumHealth Behavioral Solutions (OHBS). Contact Molina if services are rendered by a Medical Healthcare Provider. | |
| H2012 | BEHAVIORAL HEALTH DAY TREATMENT PER HOUR | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | For services rendered by a Behavioral Health Provider, contact OptumHealth Behavioral Solutions (OHBS). Contact Molina if services are rendered by a Medical Healthcare Provider. | |
| H2013 | PSYCHIATRIC HEALTH FACILITY SERVICE PER DIEM | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | For services rendered by a Behavioral Health Provider, contact OptumHealth Behavioral Solutions (OHBS). Contact Molina if services are rendered by a Medical Healthcare Provider. | |
| H2015 | COMP COMMUNITY SUPPORT SERVICES PER 15 MINUTES | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | For services rendered by a Behavioral Health Provider, contact OptumHealth Behavioral Solutions (OHBS). Contact Molina if services are rendered by a Medical Healthcare Provider. | |
| H2016 | COMP COMMUNITY SUPPORT SERVICES PER DIEM | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | For services rendered by a Behavioral Health Provider, contact OptumHealth Behavioral Solutions (OHBS). Contact Molina if services are rendered by a Medical Healthcare Provider. | |
| H2018 | PSYCHOSOCIAL REHABILITATION SERVICES PER DIEM | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | For services rendered by a Behavioral Health Provider, contact OptumHealth Behavioral Solutions (OHBS). Contact Molina if services are rendered by a Medical Healthcare Provider. | |
| H2020 | THERAPEUTIC BEHAVIORAL SERVICES PER DIEM | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | For services rendered by a Behavioral Health Provider, contact OptumHealth Behavioral Solutions (OHBS). Contact Molina if services are rendered by a Medical Healthcare Provider. | |
| H2036 | ALCOHOLAND OR OTH DRUG TREATMENT PROGRAM PER DIEM | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | For services rendered by a Behavioral Health Provider, contact OptumHealth Behavioral Solutions (OHBS). Contact Molina if services are rendered by a Medical Healthcare Provider. | |
| S0201 | PARTIAL HOSPITLZTN SERVICES UNDER 24 HR PER DIEM | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | For services rendered by a Behavioral Health Provider, contact OptumHealth Behavioral Solutions (OHBS). Contact Molina if services are rendered by a Medical Healthcare Provider. | |

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| S9480 | INTENSIVE OP PSYCHIATRIC SERVICES PER DIEM | Behavioral/Mental Health, Alcohol-Chemical Dependency | Y | | For services rendered by a Behavioral Health Provider, contact OptumHealth Behavioral Solutions (OHBS). Contact Molina if services are rendered by a Medical Healthcare Provider. | |
| 15775 | PUNCH GRAFT HAIR TRANSPLANT 1-15 PUNCH GRAFTS | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 15776 | PUNCH GRAFT HAIR TRANSPLANT OVER 15 PUNCH GRAFTS | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 15780 | DERMABRASION TOTAL FACE | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 15781 | DERMABRASION SEGMENTAL FACE | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 15782 | DERMABRASION REGIONAL OTHER THAN FACE | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 15783 | DERMABRASION SUPERFICIAL ANY SITE | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 15788 | CHEMICAL PEEL FACIAL EPIDERMAL | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 15789 | CHEMICAL PEEL FACIAL DERMAL | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 15792 | CHEMICAL PEEL NONFACIAL EPIDERMAL | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 15793 | CHEMICAL PEEL NONFACIAL DERMAL | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 15820 | BLEPHAROPLASTY LOWER EYELID | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 15821 | BLEPHAROPLASTY LOWER EYELID HERNIATED FAT PAD | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 15822 | BLEPHAROPLASTY UPPER EYELID | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 15823 | BLEPHAROPLASTY UPPER EYELID W EXCESSIVE SKIN | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 15824 | RHYTIDECTOMY FOREHEAD | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 15825 | RHYTIDECTOMY NECK W PLATYSMAL TIGHTENING | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 15826 | RHYTIDECTOMY GLABELLAR FROWN LINES | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 15828 | RHYTIDECTOMY CHEEK CHIN AND NECK | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 15829 | RHYTIDECTOMY SMAS FLAP | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 15832 | EXCISION EXCESSIVE SKIN AND SUBQ TISSUE THIGH | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 15833 | EXCISION EXCESSIVE SKIN AND SUBQ TISSUE LEG | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 15834 | EXCISION EXCESSIVE SKIN AND SUBQ TISSUE HIP | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 15835 | EXCISION EXCESSIVE SKIN AND SUBQ TISSUE BUTTOCK | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 15836 | EXCISION EXCESSIVE SKIN AND SUBQ TISSUE ARM | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 15837 | EXC EXCESSIVE SKIN AND SUBQ TISSUE FOREARM HAND | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 15838 | EXC EXCSV SKIN AND SUBQ TISSUE SUBMENTAL FAT PAD | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 15839 | EXCISION EXCESSIVE SKIN AND SUBQ TISSUE OTHER AREA | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 15847 | EXCISION EXCESSIVE SKIN AND SUBQ TISSUE ABDOMEN | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 15876 | SUCTION ASSISTED LIPECTOMY HEAD AND NECK | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 15877 | SUCTION ASSISTED LIPECTOMY TRUNK | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 15878 | SUCTION ASSISTED LIPECTOMY UPPER EXTREMITY | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 15879 | SUCTION ASSISTED LIPECTOMY LOWER EXTREMITY | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 17380 | ELECTROLYSIS EPILATION EACH 30 MINUTES | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 19300 | MASTECTOMY GYNECOMASTIA | Cosmetic, Plastic & Reconstructive Procedures | Y | | No PA required when associated with breast cancer diagnoses. | |
| 19303 | MASTECTOMY SIMPLE COMPLETE | Cosmetic, Plastic & Reconstructive Procedures | Y | | No PA required when associated with breast cancer diagnoses. | |
| 19316 | MASTOPEXY | Cosmetic, Plastic & Reconstructive Procedures | Y | | No PA required when associated with breast cancer diagnoses. | |
| 19318 | REDUCTION MAMMAPLASTY | Cosmetic, Plastic & Reconstructive Procedures | Y | | No PA required when associated with breast cancer diagnoses. | |
| 19325 | MAMMAPLASTY AUGMENTATION W PROSTHETIC IMPLANT | Cosmetic, Plastic & Reconstructive Procedures | Y | | No PA required when associated with breast cancer diagnoses. | |
| 19328 | REMOVAL INTACT MAMMARY IMPLANT | Cosmetic, Plastic & Reconstructive Procedures | Y | | No PA required when associated with breast cancer diagnoses. | |
| 19330 | REMOVAL MAMMARY IMPLANT MATERIAL | Cosmetic, Plastic & Reconstructive Procedures | Y | | No PA required when associated with breast cancer diagnoses. | |
| 19340 | IMMT INSJ BRST PROSTH FLWG MASTOPEXY MAST RCNSTJ | Cosmetic, Plastic & Reconstructive Procedures | Y | | No PA required when associated with breast cancer diagnoses. | |
| 19342 | DLYD INSJ BRST PROSTH FLWG MASTOPEXY MAST RCNSTJ | Cosmetic, Plastic & Reconstructive Procedures | Y | | No PA required when associated with breast cancer diagnoses. | |
| 19350 | NIPPLE AREOLA RECONSTRUCTION | Cosmetic, Plastic & Reconstructive Procedures | Y | | No PA required when associated with breast cancer diagnoses. | |
| 19355 | CORRECTION INVERTED NIPPLES | Cosmetic, Plastic & Reconstructive Procedures | Y | | No PA required when associated with breast cancer diagnoses. | |
| 19396 | PREPARATION MOULAGE CUSTOM BREAST IMPLANT | Cosmetic, Plastic & Reconstructive Procedures | Y | | No PA required when associated with breast cancer diagnoses. | |
| 30400 | RHINP PRIM LAT AND ALAR CRTLGS AND ELVTN NASAL TI | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 30410 | RHINP PRIM COMPLETE XTRNL PARTS | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |

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| 30420 | RHINOPLASTY PRIMARY W MAJOR SEPTAL REPAIR | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 30430 | RHINOPLASTY SECONDARY MINOR REVISION | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 30435 | RHINOPLASTY SECONDARY INTERMEDIATE REVISION | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 30450 | RHINOPLASTY SECONDARY MAJOR REVISION | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 30460 | RHINP DFRM W COLUM LNGTH TIP ONLY | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 30462 | RHINP DFRM COLUM LNGTH TIP SEPTUM OSTEOT | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 30468 | RPR NSL VLV COLLAPSE SUBQ/SBMCSL LAT WALL IMPLT | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 67900 | REPAIR BROW PTOSIS | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 67901 | RPR BLEPHAROPTOSIS FRONTALIS MUSC SUTR OTH MATRL | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 67902 | RPR BLEPHAROPT FRONTALIS MUSC AUTOL FASCAL SLING | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 67903 | RPR BLEPHAROPTOSIS LEVATOR RESCJ ADVMNT INTERNAL | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 67904 | RPR BLEPHAROPTOSIS LEVATOR RESCJ ADVMNT XTRNL | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 67906 | RPR BLEPHAROPTOSIS SUPERIOR RECTUS FASCIAL SLING | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 67908 | RPR BLPOS CONJUNCTIVO-TARSO-MUSC-LEVATOR RESCJ | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 67909 | REDUCTION OVERCORRECTION PTOSIS | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 67950 | CANTHOPLASTY | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| 69300 | OTOPLASTY PROTRUDING EAR W/WO SIZE RDCTN | Cosmetic, Plastic & Reconstructive Procedures | Y | | | |
| A4238 | SPL ALW ADJ CGM SPL AND ACCESS 1 MO SPL EQUAL TO 1 U SRV | Durable Medical Equipment (DME) | Y | | Services covered under pharmacy benefit. | |
| A4239 | SPLY ALW NONADJUNC NONIMPL CGM 1 MO SPLY Equal to 1 UOS | Durable Medical Equipment (DME) | Y | | Services covered under pharmacy benefit. | |
| A4341 | INDWELL IU DRAIN DEVC VLV PT INSRT REPLC ONLY EA | Durable Medical Equipment (DME) | Y | | | |
| A4342 | ACC PT INS INDWELL IU DRN DEVC VLV REPLC ONLY EA | Durable Medical Equipment (DME) | Y | | | |
| A4560 | NEUROMUSCULAR ELECTRICAL STIM DISP REPLC ONLY | Durable Medical Equipment (DME) | Y | | | |
| A9274 | EXTERNAL AMB INSULIN DEL SYSTEM DISPOSABLE EA | Durable Medical Equipment (DME) | Y | | | |
| A9276 | SENSOR;INVSV DISPSBLE INTRSTL CGM 1U EQLS 1D SPPLY | Durable Medical Equipment (DME) | Y | | Services covered under pharmacy benefit. | |
| A9277 | TRANSMITTER; EXT INTERSTITIAL CONT GLU MON SYS | Durable Medical Equipment (DME) | Y | | Services covered under pharmacy benefit. | |
| A9278 | RECEIVER MON; EXT INTERSTITIAL CONT GLU MON SYS | Durable Medical Equipment (DME) | Y | | Services covered under pharmacy benefit. | |
| B4105 | IN-LINE CART CTG DIG ENZYME ENTERAL FEEDING EA | Durable Medical Equipment (DME) | Y | | | |
| C2624 | IMPL WIRELESS PULM ARTERY PRESS SENSOR DEL CATH | Durable Medical Equipment (DME) | Y | | | |
| E0194 | AIR FLUIDIZED BED | Durable Medical Equipment (DME) | Y | | | |
| E0255 | HOSP BED VARIBL HT W ANY TYPE SIDE RAIL W MATTRSS | Durable Medical Equipment (DME) | Y | | | |
| E0260 | HOSP BED SEMI-ELEC W ANY TYPE SIDE RAIL W MATTRSS | Durable Medical Equipment (DME) | Y | | | |
| E0261 | HOSP BED SEMI-ELEC ANY TYPE SIDE RAIL W O MATTRSS | Durable Medical Equipment (DME) | Y | | | |
| E0265 | HOSP BED TOT ELCTRC W ANY TYPE SIDE RAIL W MTTRSS | Durable Medical Equipment (DME) | Y | | | |
| E0266 | HOS BED TTL ELCTRC ANY TYPE SIDE RAIL W/O MTTRSS | Durable Medical Equipment (DME) | Y | | | |
| E0277 | POWERED PRESSURE-REDUCING AIR MATTRESS | Durable Medical Equipment (DME) | Y | | | |
| E0292 | HOSP BED VARIBL HT HI-LO W O SIDE RAIL W MATTRSS | Durable Medical Equipment (DME) | Y | | | |
| E0293 | HOSP BED VARIBL HT HI-LO W O SIDE RAIL NO MATTRSS | Durable Medical Equipment (DME) | Y | | | |
| E0294 | HOSP BED SEMI-ELEC W O SIDE RAILS W MATTRSS | Durable Medical Equipment (DME) | Y | | | |
| E0295 | HOSP BED SEMI-ELEC W O SIDE RAILS W O MATTRSS | Durable Medical Equipment (DME) | Y | | | |
| E0296 | HOSP BED TOTAL ELEC W O SIDE RAILS W MATTRSS | Durable Medical Equipment (DME) | Y | | | |
| E0297 | HOSP BED TOTAL ELEC W O SIDE RAILS W O MATTRSS | Durable Medical Equipment (DME) | Y | | | |
| E0300 | PED CRIB HOS GRADE FULLY ENC W WO TOP ENC | Durable Medical Equipment (DME) | Y | | | |
| E0301 | HOSP BED HVY DTY XTRA WIDE W WGHT CAPACTY OVER 350 PDS | Durable Medical Equipment (DME) | Y | | | |
| E0302 | HOSP BED XTRA HVY DTY WT CAP OVER 600 PDS W O MTTRSS | Durable Medical Equipment (DME) | Y | | | |
| E0303 | HOSP BED HEVY DUTY W WT CAP OVER 350 PDS UNDER EQ TO 600 | Durable Medical Equipment (DME) | Y | | | |
| E0304 | HOSP BED EXTRA HEAVY DUTY WT CAP OVER 600 PDS MATTRSS | Durable Medical Equipment (DME) | Y | | | |
| E0316 | SFTY ENCLOS FRME/CANOPY USE W/HOSP BED ANY TYPE | Durable Medical Equipment (DME) | Y | | | |
| E0328 | HOSP BED PEDIATRIC MANUAL INCLUDES MATTRESS | Durable Medical Equipment (DME) | Y | | | |
| E0329 | HOSP BED PEDIATRIC ELECTRIC INCLUDE MATTRESS | Durable Medical Equipment (DME) | Y | | | |
| E0371 | NONPWR ADV PRSS RDUC OVRLAY MATTRSS STD LEN AND WDTH | Durable Medical Equipment (DME) | Y | | | |

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| E0372 | PWR AIR OVRLAY MATTRSS STD MATTRSS LENGTH AND WIDTH | Durable Medical Equipment (DME) | Y | | | |
| E0373 | NONPOWERED ADVANCD PRESSURE REDUCING MATTRESS | Durable Medical Equipment (DME) | Y | | | |
| E0462 | ROCKING BED WITH OR WITHOUT SIDE RAILS | Durable Medical Equipment (DME) | Y | | | |
| E0465 | HOME VENTILATOR ANY TYPE USED W INVASIVE INTF | Durable Medical Equipment (DME) | Y | | | |
| E0466 | HOME VENTILATOR ANY TYPE USED W NON-INVASV INTF | Durable Medical Equipment (DME) | Y | | | |
| E0467 | HOME VENTILATOR MULTI-FUNCTION RESPIRATORY DEVC | Durable Medical Equipment (DME) | Y | | | |
| E0468 | HOME VENT DF RESP DVC PER ADD FUNC OF COUGH STIM | Durable Medical Equipment (DME) | Y | | | |
| E0470 | RESP ASST DEVC BI-LEVL PRSS CAPABILITY W/O BACKU | Durable Medical Equipment (DME) | Y | | | |
| E0471 | RESP ASST DEVC BI-LEVL PRSS CAPABILITY W/BACK-UP | Durable Medical Equipment (DME) | Y | | | |
| E0472 | RESP ASST DEVC BI-LEVL PRSS CAPABILITY W/BACKUP | Durable Medical Equipment (DME) | Y | | | |
| E0481 | INTRAPULM PERCUSSIVE VENT SYSTEM AND REL ACSSORIES | Durable Medical Equipment (DME) | Y | | | |
| E0483 | HI FREQNCY CHEST WALL OSCILLATION SYSTEM EA | Durable Medical Equipment (DME) | Y | | | |
| E0486 | ORL DEVC/APPL RDUC UP AIRWAY COLLAPSIBILITY CSTM | Durable Medical Equipment (DME) | Y | | | |
| E0492 | PS AND CTRL ELEC U O DVC/APPL NM ELEC STIM TNG M | Durable Medical Equipment (DME) | Y | | | |
| E0493 | ORAL DEVICE/APPL NM ELEC STIM TONGUE MUSCLE | Durable Medical Equipment (DME) | Y | | | |
| E0637 | COMB SIT STAND FRAME/TABLE SYS SEATLIFT FEATURE | Durable Medical Equipment (DME) | Y | | | |
| E0638 | STANDING FRAME/TABLE SYS ONE PSTION ANY SZ W/WO WHLS | Durable Medical Equipment (DME) | Y | | | |
| E0640 | PATIENT LIFT FIX SYS INCLUDES ALL CMPNTS/ACCESS | Durable Medical Equipment (DME) | Y | | | |
| E0641 | FORM-FITTING CONDUCTIVE GARMENT DELIV TENS/NMES | Durable Medical Equipment (DME) | Y | | | |
| E0642 | STANDING FRAME/TABLE SYS MOBILE DYNAMIC ANY SZ | Durable Medical Equipment (DME) | Y | | | |
| E0651 | PNEUMATC COMPRS SEG HOM MDL NO CALBRTD GRDNT PRSS | Durable Medical Equipment (DME) | Y | | | |
| E0652 | PNEUMAT COMPRS SEG HOM MDL W/CALBRTD GRADNT PRSS | Durable Medical Equipment (DME) | Y | | | |
| E0656 | SEG PNEUMAT APPLIANCE USE W PNEUMAT COMPRS TRUNK | Durable Medical Equipment (DME) | Y | | | |
| E0667 | SEG PNEUMAT APPLINC W PNEUMAT COMPRS FULL LEG | Durable Medical Equipment (DME) | Y | | | |
| E0668 | SEG PNEUMAT APPLINC W PNEUMAT COMPRS FULL ARM | Durable Medical Equipment (DME) | Y | | | |
| E0671 | SEGMENTAL GRADENT PRESS PNEUMAT APPLINC FULL LEG | Durable Medical Equipment (DME) | Y | | | |
| E0675 | PNEUMAT COMPRS DEVC HI PRSS RAPID INFLATION DEFL | Durable Medical Equipment (DME) | Y | | | |
| E0676 | INTERMITTENT LIMB COMPRESSION DEVICE NOS | Durable Medical Equipment (DME) | Y | | | |
| E0677 | NONPNEUMATIC SEQUENTIAL COMP GARMENT TRUNK | Durable Medical Equipment (DME) | Y | | | |
| E0691 | UV LIGHT TX SYS BULB LAMP TIMER; TX 2 SQ FT LESS | Durable Medical Equipment (DME) | Y | | | |
| E0692 | UV LT TX SYS PANL W BULB LAMP TIMER 4 FT PANEL | Durable Medical Equipment (DME) | Y | | | |
| E0693 | UV LT TX SYS PANL W BULBS LAMPS TIMER 6 FT PANEL | Durable Medical Equipment (DME) | Y | | | |
| E0694 | UV MX DIR LT TX SYS 6 FT CABINET W BULB LAMP TMR | Durable Medical Equipment (DME) | Y | | | |
| E0747 | OSTOGNS STIM ELEC NONINVASV OTH THAN SP APPLIC | Durable Medical Equipment (DME) | Y | | | |
| E0748 | OSTOGNS STIMULATOR ELEC NONINVASV SPINAL APPLIC | Durable Medical Equipment (DME) | Y | | | |
| E0749 | OSTEOGENESIS STIMULATOR ELEC SURGICALLY IMPL | Durable Medical Equipment (DME) | Y | | | |
| E0760 | OSTOGNS STIM LOW INTENS ULTRASOUND NON-INVASV | Durable Medical Equipment (DME) | Y | | | |
| E0762 | TRANSCUT ELEC JOINT STIM DEVC SYS INCL ALL ACCSS | Durable Medical Equipment (DME) | Y | | | |
| E0764 | FUNC NEUROMUSC STIM MUSC AMBUL CMPT CNTRL SC INJ | Durable Medical Equipment (DME) | Y | | | |
| E0766 | ELEC STIM DVC U CANCER TX INCL ALL ACC ANY TYPE | Durable Medical Equipment (DME) | Y | | | |
| E0782 | INFUSION PUMP IMPLANTABLE NON-PROGRAMMABLE | Durable Medical Equipment (DME) | Y | | | |
| E0783 | INFUSION PUMP SYSTEM IMPLANTABLE PROGRAMMABLE | Durable Medical Equipment (DME) | Y | | | |
| E0784 | EXTERNAL AMBULATORY INFUSION PUMP INSULIN | Durable Medical Equipment (DME) | Y | | | |
| E0785 | IMPLANTABLE INTRASPINL CATHETER USED W PUMP-REPL | Durable Medical Equipment (DME) | Y | | | |
| E0786 | IMPLANTABLE PROGRAMMABLE INFUSION PUMP REPL | Durable Medical Equipment (DME) | Y | | | |
| E0787 | EXTERNAL AMB INFUS PUMP INSULIN DOS RATE ADJ | Durable Medical Equipment (DME) | Y | | | |
| E0983 | MNL WC ACSS PWR ADD-ON CONVRT MNL WC MOTRIZD WC JOYST CNTRL | Durable Medical Equipment (DME) | Y | | | |
| E0984 | MNL WC ACSS PWR ADD-ON CONVRT MNL WC MOTRIZD WC TILLER CNTRL | Durable Medical Equipment (DME) | Y | | | |

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| E0986 | MNL WHEELCHAIR ACSS PUSH-RIM ACT PWR ASSIST SYS | Durable Medical Equipment (DME) | Y | | | |
| E0988 | MANUAL WC ACCESSORY LEVR-ACTIVATD WHL DRIVE PAIR | Durable Medical Equipment (DME) | Y | | | |
| E1002 | WHEELCHAIR ACCESS POWER SEATING SYSTEM TILT ONLY | Durable Medical Equipment (DME) | Y | | | |
| E1003 | WC ACSS PWR SEAT SYS RECLINE W O SHEAR RDUC | Durable Medical Equipment (DME) | Y | | | |
| E1004 | WC ACSS PWR SEAT SYS RECLINE W MECH SHEAR RDUC | Durable Medical Equipment (DME) | Y | | | |
| E1005 | WC ACSS PWR SEAT SYS RECLINE W PWR SHEAR RDUC | Durable Medical Equipment (DME) | Y | | | |
| E1006 | WC ACSS PWR SEAT SYS TILT AND RECLINE NO SHEAR RDUC | Durable Medical Equipment (DME) | Y | | | |
| E1007 | WC ACSS PWR SEAT TILT AND RECLINE MECH SHEAR RDUC | Durable Medical Equipment (DME) | Y | | | |
| E1008 | WC ACSS PWR SEAT TILT AND RECLINE W PWR SHEAR RDUC | Durable Medical Equipment (DME) | Y | | | |
| E1010 | WC ACCSS ADD PWR SEAT SYS PWR LEG ELEV SYS PAIR | Durable Medical Equipment (DME) | Y | | | |
| E1012 | WC ACCSS PWR SEAT SYS CNTR MNT PWR ELEV LEG EA | Durable Medical Equipment (DME) | Y | | | |
| E1030 | WHEELCHAIR ACCESSORY VENTILATOR TRAY GIMBALED | Durable Medical Equipment (DME) | Y | | | |
| E1161 | MANUAL ADULT SIZE WHEELCHAIR INCLUDES TILT SPACE | Durable Medical Equipment (DME) | Y | | | |
| E1229 | WHEELCHAIR PEDIATRIC SIZE NOS | Durable Medical Equipment (DME) | Y | | | |
| E1230 | PWR OPERATED VEH SPEC BRAND NAME AND MODEL NUMBER | Durable Medical Equipment (DME) | Y | | | |
| E1232 | WC PED SZ TILT-IN-SPACE FOLD ADJUSTBL W SEAT SYS | Durable Medical Equipment (DME) | Y | | | |
| E1233 | WC PED SZ TILT-IN-SPACE RIGD ADJUSTBL W O SEAT | Durable Medical Equipment (DME) | Y | | | |
| E1234 | WC PED SZ TILT-IN-SPACE FOLD ADJUSTBL W O SEAT | Durable Medical Equipment (DME) | Y | | | |
| E1235 | WHLCHAIR PED SIZE RIGD ADJUSTBL W SEATING SYSTEM | Durable Medical Equipment (DME) | Y | | | |
| E1236 | WHLCHAIR PED SIZE FOLD ADJUSTBL W SEATING SYSTEM | Durable Medical Equipment (DME) | Y | | | |
| E1237 | WHLCHAIR PED SZ RIGD ADJUSTBL W O SEATING SYSTEM | Durable Medical Equipment (DME) | Y | | | |
| E1238 | WHLCHAIR PED SZ FOLD ADJUSTBL W O SEATING SYSTEM | Durable Medical Equipment (DME) | Y | | | |
| E1390 | O2 CONC 1 DEL PORT 85 PCT OR GT 02 CONC AT PRSC FLW RATE | Durable Medical Equipment (DME) | Y | | | |
| E1391 | O2 CONC 2 DEL PORT 85 PCT OR GT O2 CONC PRSC FLW RATE EA | Durable Medical Equipment (DME) | Y | | | |
| E1905 | VIRTUAL REALITY CBT INCLUDING PP TX SOFTWARE | Durable Medical Equipment (DME) | Y | | | |
| E2102 | ADJUNCTIVE CONTINUOUS GLUCOSE MONITOR/RECEIVER | Durable Medical Equipment (DME) | Y | | Services covered under pharmacy benefit. | |
| E2103 | NONADJUNCTIVE NONIMPLANTED CGM/RECEIVER | Durable Medical Equipment (DME) | Y | | Services covered under pharmacy benefit. | |
| E2295 | MNL WC ACCESS PED SIZE WC DYNAMIC SEATING FRAME | Durable Medical Equipment (DME) | Y | | | |
| E2298 | COMPLEX REHAB PWR WC ACC PWR SEAT EL SYS ANY TYP | Durable Medical Equipment (DME) | Y | | | |
| E2301 | WHEELCHAIR ACCESSORY POWER STANDING SYS ANY TYPE | Durable Medical Equipment (DME) | Y | | | |
| E2310 | PWR WC ACSS ELEC CNCT BETWN WC CNTRLLER AND ONE PWR | Durable Medical Equipment (DME) | Y | | | |
| E2311 | PWR WC ACSS ELEC CNCT BETWN WC CNTRLLER AND TWO MORE | Durable Medical Equipment (DME) | Y | | | |
| E2312 | POWER WC ACCESS HAND OR CHIN CONTROL INTERFACE | Durable Medical Equipment (DME) | Y | | | |
| E2313 | POWER WC ACCESS HARNESS UPGRADE EXP CONTROLLR EA | Durable Medical Equipment (DME) | Y | | | |
| E2321 | PWR WC ACSS HND CNTRL REMOT JOYSTCK NO PRPRTNL | Durable Medical Equipment (DME) | Y | | | |
| E2322 | PWR WC ACSS HND CNTRL MX MECH SWTCH NO PRPRTNL | Durable Medical Equipment (DME) | Y | | | |
| E2325 | PWR WC ACSS SIP AND PUFF INTERFCE NONPROPRTNAL | Durable Medical Equipment (DME) | Y | | | |
| E2327 | PWR WC ACSS HEAD CNTRL INTERFCE MECH PROPRTNAL | Durable Medical Equipment (DME) | Y | | | |
| E2328 | PWR WC ACSS HEAD CNTRL EXT CNTRL ELEC PRPRTNL | Durable Medical Equipment (DME) | Y | | | |
| E2329 | PWR WC ACSS HEAD CNTRL CNTC SWTCH MECH NOPRPRTNL | Durable Medical Equipment (DME) | Y | | | |
| E2330 | PWR WC ACCSS HEAD PROX SWITCH MECH NONPRPRTNL | Durable Medical Equipment (DME) | Y | | | |
| E2340 | POWER WC ACCESS NONSTAND SEAT FRAME WD 20-23 IN | Durable Medical Equipment (DME) | Y | | | |
| E2341 | PWR WC ACSS NONSTD SEAT FRME WIDTH 24-27 IN | Durable Medical Equipment (DME) | Y | | | |
| E2342 | PWR WC ACSS NONSTD SEAT FRME DEPTH 20 21 IN | Durable Medical Equipment (DME) | Y | | | |
| E2343 | PWR WC ACSS NONSTD SEAT FRME DEPTH 22-25 IN | Durable Medical Equipment (DME) | Y | | | |
| E2351 | PWR WC ACSS ELEC INTERFCE OPERATE SPCH GEN DEVC | Durable Medical Equipment (DME) | Y | | | |
| E2369 | POWER WC CMPNNT DRIVE WHEEL GEAR BOX REPL ONLY | Durable Medical Equipment (DME) | Y | | | |
| E2370 | PWR WC COMP INT DR WHL MTR AND GR BOX COMB REPL ONLY | Durable Medical Equipment (DME) | Y | | | |
| E2373 | PWR WC MINI-PROPORTIONAL COMPACT REMOTE JOYSTICK | Durable Medical Equipment (DME) | Y | | | |
| E2375 | PWR WC NONEXPNDABLE CONTROLLER REPLACEMENT ONLY | Durable Medical Equipment (DME) | Y | | | |

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| E2376 | PWR WC EXPANDABLE CONTROLLER REPLACEMENT ONLY | Durable Medical Equipment (DME) | Y | | | |
| E2377 | PWR WC EXPANDABLE CONTROLLER UPGRADE INIT ISSUE | Durable Medical Equipment (DME) | Y | | | |
| E2398 | WHEELCHAIR ACC, DYNAMIC POS HARDWARE FOR BACK | Durable Medical Equipment (DME) | Y | | | |
| E2402 | NEG PRESS WOUND THERAPY ELEC PUMP STATION/PRTBLE | Durable Medical Equipment (DME) | Y | | | |
| E2500 | SPEECH GEN DEVC DIGITIZED UNDER EQ 8 MINS REC TIME | Durable Medical Equipment (DME) | Y | | | |
| E2502 | SPCH GEN DEVC DIGTIZD OVER 8 MINS LESS THN EQ 20 MIN REC | Durable Medical Equipment (DME) | Y | | | |
| E2504 | SPCH GEN DEVC DIGTIZD OVER 20 MINS UNDER EQ 40 MINS REC | Durable Medical Equipment (DME) | Y | | | |
| E2506 | SPEECH GEN DEVICE DIGITIZED OVER 40 MINS REC TIME | Durable Medical Equipment (DME) | Y | | | |
| E2508 | SPCH GEN DEVC SYNTHSIZD REQ MESS SPELL AND CNTCT | Durable Medical Equipment (DME) | Y | | | |
| E2510 | SPCH GEN DEVC SYNTHESIZD MX METH MESS AND DEVC ACCSS | Durable Medical Equipment (DME) | Y | | | |
| E2511 | SPEECH GEN SOFTWARE PROG PC PERS DIGITAL ASSIST | Durable Medical Equipment (DME) | Y | | | |
| E2512 | ACCESS SPEECH GENERATING DEVICE MOUNTING SYSTEM | Durable Medical Equipment (DME) | Y | | | |
| E2599 | ACCESSORY FOR SPEECH GENERATING DEVICE NOC | Durable Medical Equipment (DME) | Y | | | |
| E2609 | CUSTOM FABRICATED WHEELCHAIR SEAT CUSHION SIZE | Durable Medical Equipment (DME) | Y | | | |
| E2617 | CSTM FAB WC BACK CUSHN ANY SZ ANY MOUNT HARDWARE | Durable Medical Equipment (DME) | Y | | | |
| E2626 | WC ACCESS SHLDR ELB MOBIL ARM SUPP WC ADJUSTBLE | Durable Medical Equipment (DME) | Y | | | |
| E2628 | WC ACCESS SHLDR ELB MOBIL ARM SUPP WC RECLINING | Durable Medical Equipment (DME) | Y | | | |
| E2629 | WC ACCESS SHLDR ELB M ARM SUPP FRICTION ARM SUPP | Durable Medical Equipment (DME) | Y | | | |
| K0005 | ULTRALIGHTWEIGHT WHEELCHAIR | Durable Medical Equipment (DME) | Y | | | |
| K0008 | CUSTOM MANUAL WHEELCHAIR BASE | Durable Medical Equipment (DME) | Y | | | |
| K0009 | OTHER MANUAL WHEELCHAIR/BASE | Durable Medical Equipment (DME) | Y | | | |
| K0010 | STANDARD-WEIGHT FRAME MOTORIZED POWER WHEELCHAIR | Durable Medical Equipment (DME) | Y | | | |
| K0011 | STD-WT FRME MOTRIZD PWR WHLCHAIR W PROG CNTRL | Durable Medical Equipment (DME) | Y | | | |
| K0012 | LIGHTWEIGHT PORTABLE MOTORIZED POWER WHEELCHAIR | Durable Medical Equipment (DME) | Y | | | |
| K0013 | CUSTOM MOTORIZED POWER WHEELCHAIR BASE | Durable Medical Equipment (DME) | Y | | | |
| K0014 | OTHER MOTORIZED POWER WHEELCHAIR BASE | Durable Medical Equipment (DME) | Y | | | |
| K0108 | OTHER ACCESSORIES | Durable Medical Equipment (DME) | Y | | | |
| K0606 | AUTO EXT DEFIB W INTGR ECG ANALY GARMENT TYPE | Durable Medical Equipment (DME) | Y | | | |
| K0800 | PWR OP VEH GRP 1 STD PT WT CAP TO AND INCL 300 LBS | Durable Medical Equipment (DME) | Y | | | |
| K0801 | PWR OP VEH GRP 1 HEAVY DUTY PT 301 TO 450 LBS | Durable Medical Equipment (DME) | Y | | | |
| K0802 | PWR OP VEH GRP 1 VERY HEAVY DUTY PT 451-600 LBS | Durable Medical Equipment (DME) | Y | | | |
| K0806 | PWR OP VEH GRP 2 STD PT WT CAP TO AND INCL 300 LBS | Durable Medical Equipment (DME) | Y | | | |
| K0807 | PWR OP VEH GRP 2 HEAVY DUTY PT 301 TO 450 LBS | Durable Medical Equipment (DME) | Y | | | |
| K0808 | PWR OP VEH GRP 2 VERY HEAVY DUTY PT 451-600 LBS | Durable Medical Equipment (DME) | Y | | | |
| K0812 | POWER OPERATED VEHICLE NOT OTHERWISE CLASSIFIED | Durable Medical Equipment (DME) | Y | | | |
| K0813 | PWR WC GRP 1 STD PORT SLING SEAT PT TO 300 LBS | Durable Medical Equipment (DME) | Y | | | |
| K0814 | PWR WC GRP 1 STD PORT CAPT CHAIR PT TO 300 LBS | Durable Medical Equipment (DME) | Y | | | |
| K0815 | PWR WC GRP 1 STD SLING SEAT PT UP TO AND EQ 300 LBS | Durable Medical Equipment (DME) | Y | | | |
| K0816 | PWR WC GRP 1 STD CAPTAINS CHAIR PT TO AND EQ 300 LBS | Durable Medical Equipment (DME) | Y | | | |
| K0820 | PWR WC GRP 2 STD PORT SLING SEAT PT TO AND EQ 300 LBS | Durable Medical Equipment (DME) | Y | | | |
| K0821 | PWR WC GRP 2 STDRD PORT CAPT CHAIR PT UPTO INCLDNG 300 LBS | Durable Medical Equipment (DME) | Y | | | |
| K0822 | PWR WC GRP 2 STD SLING SEAT PT TO AND EQ 300 LBS | Durable Medical Equipment (DME) | Y | | | |
| K0823 | PWR WC GRP 2 STD CAPTAINS CHAIR PT TO & EQ 300 LBS | Durable Medical Equipment (DME) | Y | | | |
| K0824 | PWR WC GRP 2 HEVY DUTY SLING SEAT PT 301-450 LBS | Durable Medical Equipment (DME) | Y | | | |
| K0825 | PWR WC GRP 2 HEVY DUTY CAPT CHAIR PT 301-450 LBS | Durable Medical Equipment (DME) | Y | | | |
| K0826 | PWR WC GRP 2 VRY HVY DTY SLNG SEAT PT 451-600 LB | Durable Medical Equipment (DME) | Y | | | |
| K0827 | PWR WC GRP 2 VRY HVY DTY CAPT CHR PT 451-600 LBS | Durable Medical Equipment (DME) | Y | | | |
| K0828 | PWR WC GRP 2 XTRA HVY DUTY SLING SEAT PT 601LB OR GRT | Durable Medical Equipment (DME) | Y | | | |
| K0829 | PWR WC GRP 2 XTRA HVY DUTY CHAIR PT 601 LBS OR GRT | Durable Medical Equipment (DME) | Y | | | |

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| K0830 | PWR WC GRP 2 STD SEAT ELEV SLING PT TO AND EQ 300 LBS | Durable Medical Equipment (DME) | Y | | | |
| K0831 | PWR WC GRP 2 STD SEAT ELEV CAP CHR PT TO 300 LB | Durable Medical Equipment (DME) | Y | | | |
| K0835 | PWR WC GRP 2 STD 1 PWR SLING SEAT PT TO 300 LBS | Durable Medical Equipment (DME) | Y | | | |
| K0836 | PWR WC GRP 2 STD 1 PWR CAPT CHAIR PT TO 300 LBS | Durable Medical Equipment (DME) | Y | | | |
| K0837 | PWR WC GRP 2 HVY 1 PWR SLING SEAT PT 301-450 LBS | Durable Medical Equipment (DME) | Y | | | |
| K0838 | PWR WC GRP 2 HVY 1 PWR CAPT CHAIR PT 301-450 LBS | Durable Medical Equipment (DME) | Y | | | |
| K0839 | PWR WC GRP 2 VRY HVY 1 PWR SLING PT 451-600 LBS | Durable Medical Equipment (DME) | Y | | | |
| K0840 | PWR WC GRP 2 XTRA HVY 1 PWR SLING PT 601 LBS OR MORE | Durable Medical Equipment (DME) | Y | | | |
| K0841 | PWR WC GRP 2 MX PWR SLING SEAT PT TO AND EQ 300 LBS | Durable Medical Equipment (DME) | Y | | | |
| K0842 | PWR WC GRP 2 STD MX PWR CAPT CHR PT WT UPTO AND INCLDNG 300 LBS | Durable Medical Equipment (DME) | Y | | | |
| K0843 | PWR WC GRP 2 HVY MX PWR SLNG SEAT PT 301-450 LBS | Durable Medical Equipment (DME) | Y | | | |
| K0848 | PWR WC GRP 3 STD SLING SEAT PT TO AND EQ 300 LBS | Durable Medical Equipment (DME) | Y | | | |
| K0849 | PWR WC GRP 3 STD CAPTAIN CHAIR PT TO AND EQ 300 LBS | Durable Medical Equipment (DME) | Y | | | |
| K0850 | PWR WC GRP 3 HVY DUTY SLING SEAT PT 301-450 LBS | Durable Medical Equipment (DME) | Y | | | |
| K0851 | PWR WC GRP 3 HVY DUTY CAPT CHAIR PT 301-450 LBS | Durable Medical Equipment (DME) | Y | | | |
| K0852 | PWR WC GRP 3 V HVY DUTY SLING SEAT PT 451-600 LB | Durable Medical Equipment (DME) | Y | | | |
| K0853 | PWR WC GRP 3 HVY DUTY CAPT CHAIR PT 451-600 LBS | Durable Medical Equipment (DME) | Y | | | |
| K0854 | PWR WC GRP 3 XTRA HVY DTY SLNG SEAT PT 601 LBS OR GRT | Durable Medical Equipment (DME) | Y | | | |
| K0855 | PWR WC GRP 3X HVY DTY CHR PT WT CAP 601 LB OR GRT | Durable Medical Equipment (DME) | Y | | | |
| K0856 | PWR WC GRP 3 STD 1 PWR SLING SEAT PT TO AND EQ 300 LB | Durable Medical Equipment (DME) | Y | | | |
| K0857 | PWR WC GRP 3 STD 1 PWR CAPT CHAIR PT TO AND EQ 300 LB | Durable Medical Equipment (DME) | Y | | | |
| K0858 | PWR WC GRP 3 HD 1 PWR SLING SEAT PT 301-450 LBS | Durable Medical Equipment (DME) | Y | | | |
| K0859 | PWR WC GRP 3 HD 1 PWR CAPT CHAIR PT 301-450 LBS | Durable Medical Equipment (DME) | Y | | | |
| K0860 | PWR WC GRP 3 V HD 1 PWR SLING SEAT PT 451-600 LB | Durable Medical Equipment (DME) | Y | | | |
| K0861 | PWR WC GRP 3 STD MX PWR SLNG SEAT PT TO AND EQ 300 LB | Durable Medical Equipment (DME) | Y | | | |
| K0862 | PWR WC GRP 3 HD MX PWR SLING SEAT PT 301-450 LBS | Durable Medical Equipment (DME) | Y | | | |
| K0863 | PWR WC GRP 3 V HD MX PWR SLNG SEAT PT 451-600 LB | Durable Medical Equipment (DME) | Y | | | |
| K0864 | PWR WC GRP 3 XTR HD MX PWR SLNG SEAT PT 601 LB OR GRT | Durable Medical Equipment (DME) | Y | | | |
| K0868 | PWR WC GRP 4 STD SLING SEAT PT TO AND EQ 300 LBS | Durable Medical Equipment (DME) | Y | | | |
| K0869 | PWR WC GRP 4 STD CAPTAIN CHAIR PT TO AND EQ 300 LBS | Durable Medical Equipment (DME) | Y | | | |
| K0870 | PWR WC GRP 4 HVY DUTY SLING SEAT PT 301-450 LBS | Durable Medical Equipment (DME) | Y | | | |
| K0871 | PWR WC GRP 4 V HVY DUTY SLING SEAT PT 451-600 LB | Durable Medical Equipment (DME) | Y | | | |
| K0877 | PWR WC GRP 4 STD 1 PWR SLING SEAT PT TO AND EQ 300 LB | Durable Medical Equipment (DME) | Y | | | |
| K0878 | PWR WC GRP 4 STD 1 PWR CAPT CHAIR PT TO AND EQ 300 LB | Durable Medical Equipment (DME) | Y | | | |
| K0879 | PWR WC GRP 4 HD 1 PWR SLING SEAT PT 301-450 LBS | Durable Medical Equipment (DME) | Y | | | |
| K0880 | PWR WC GRP 4 V HD 1 PWR SLING SEAT PT 451-600 LB | Durable Medical Equipment (DME) | Y | | | |
| K0884 | PWR WC GRP 4 STD MX PWR SLNG SEAT PT TO AND EQ 300 LB | Durable Medical Equipment (DME) | Y | | | |
| K0885 | PWR WC GRP 4 STD MX PWR CAPT CHR PT TO AND EQ 300 LBS | Durable Medical Equipment (DME) | Y | | | |
| K0886 | PWR WC GRP 4 HD MX PWR SLING SEAT PT 301-450 LBS | Durable Medical Equipment (DME) | Y | | | |
| K0890 | PWR WC GRP 5 PED 1 PWR SLING SEAT PT TO AND EQ 125 LB | Durable Medical Equipment (DME) | Y | | | |
| K0891 | PWR WC GRP 5 PED MX PWR SLNG SEAT PT TO AND EQ 125 LB | Durable Medical Equipment (DME) | Y | | | |
| K0898 | POWER WHEELCHAIR NOT OTHERWISE CLASSIFIED | Durable Medical Equipment (DME) | Y | | | |
| K0899 | PWR MOBILTY DVC NOT CODED DME PDAC NOT MEET CRIT | Durable Medical Equipment (DME) | Y | | | |
| K0900 | CUSTOMIZED DME OTHER THAN WHEELCHAIR | Durable Medical Equipment (DME) | Y | | | |
| K1004 | LW FRQ U S DIA TX DVC HM USE INCL CMPNT ANDACCESS | Durable Medical Equipment (DME) | Y | | | |
| K1027 | ORAL DEV/APPL RED U AW COL WO F MCH HNG CSTM FAB | Durable Medical Equipment (DME) | Y | | | |
| Q0480 | DRIVER PNEUMATIC VAD, REP | Durable Medical Equipment (DME) | Y | | | |
| S1034 | ARTIF PANCREAS DEVC SYS THAT CMNCT W ALL DEVC | Durable Medical Equipment (DME) | Y | | | |
| S1035 | SENSOR; INVASV DSPBL USE ARTIF PANCREAS DEVC SYS | Durable Medical Equipment (DME) | Y | | | |

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| S1036 | TRANSMITTER; EXT USE W ARTIF PANCREAS DEVC SYS | Durable Medical Equipment (DME) | Y | | | |
| S1037 | RECEIVER; EXTERNAL USE W ARTIF PANCREAS DEVC SYS | Durable Medical Equipment (DME) | Y | | | |
| V5171 | HEARING AID CONTRALAT ROUT DEVICE MONAURAL ITE | Durable Medical Equipment (DME) | Y | | | |
| V5172 | HEARING AID CONTRALAT ROUT DEVICE MONAURAL ICT | Durable Medical Equipment (DME) | Y | | | |
| V5181 | HEARING AID CONTRALATERAL ROUT DVC MONAURAL BTE | Durable Medical Equipment (DME) | Y | | | |
| V5211 | HEARNG AID CNTRLTRL ROUTE SYS BINAURAL ITE/ITE | Durable Medical Equipment (DME) | Y | | | |
| V5212 | HEARING AID CONTRALAT ROUT SYS BINAURAL ITE ITC | Durable Medical Equipment (DME) | Y | | | |
| V5213 | HEARNG AID CONTRLTRL ROUT SYS BINAURAL ITE/BTE | Durable Medical Equipment (DME) | Y | | | |
| V5214 | HEARING AID CONTRALAT ROUT SYS BINAURAL ITC ITC | Durable Medical Equipment (DME) | Y | | | |
| V5215 | HEARING AID CONTRALAT ROUT SYS BINAURAL ITC BTE | Durable Medical Equipment (DME) | Y | | | |
| V5221 | HEARNG AID CONTRLTRL ROUT SYS BINAURAL BTE/BTE | Durable Medical Equipment (DME) | Y | | | |
| 27412 | AUTOLOGOUS CHONDROCYTE IMPLANTATION KNEE | Experimental/Investigational | Y | | | |
| 27415 | OSTEOCHONDRAL ALLOGRAFT KNEE OPEN | Experimental/Investigational | Y | | | |
| 27416 | OSTEOCHONDRAL AUTOGRAFT KNEE OPEN MOSAICPLASTY | Experimental/Investigational | Y | | | |
| 31242 | NASAL/SINUS NDSC DSTRJ RF ABLATION PST NSL NRV | Experimental/Investigational | Y | | | |
| 31243 | NASAL/SINUS NDSC DSTRJ CRYOABLATION PST NSL NRV | Experimental/Investigational | Y | | | |
| 43290 | ESPHGGSTRDUDNSCPY, FLXIBL, TRNSORAL; WITH DPLYMNT OF INTRGASTRIC BARIATRIC BALLON | Experimental/Investigational | Y | | | |
| 46948 | LIGATION HEMORRHOID BUNDLE W US | Experimental/Investigational | Y | | | |
| 93702 | BIS EXTRACELLULAR FLUID ALYS LYMPHEDEMA ASSMNT | Experimental/Investigational | Y | | | |
| 0101T | EXTRCORPL SHOCK WAVE MUSCSKLTL NOS HIGH ENERGY | Experimental/Investigational | Y | | | |
| 0206U | NEURO ALZHEIMER CELL AGGREGJ | Experimental/Investigational | Y | | | |
| 0207U | NEURO ALZHEIMER QUAN IMAGING | Experimental/Investigational | Y | | | |
| 0214T | NJX DX THER PARAVER FCT JT W US CER THOR 2ND LVL | Experimental/Investigational | Y | | | |
| 0215T | NJX PARAVERTBRL FACET JT W US CER THOR 3RD AND OVER LVL | Experimental/Investigational | Y | | | |
| 0216T | NJX DX THER PARAVER FCT JT W US LUMB SAC 1 LVL | Experimental/Investigational | Y | | | |
| 0217T | NJX DX THER PARAVER FCT JT W US LUMB SAC LVL 2 | Experimental/Investigational | Y | | | |
| 0218T | NJX PARAVERTBRL FCT JT W US LUMB SAC 3RD AND OVER LVL | Experimental/Investigational | Y | | | |
| 0274T | PERC LAMINO- LAMINECTOMY IMAGE GUIDE CERV THORAC | Experimental/Investigational | Y | | | |
| 0275T | PERC LAMINO- LAMINECTOMY INDIR IMAG GUIDE LUMBAR | Experimental/Investigational | Y | | | |
| 0278T | TRNSCUT ELECT MODLATION PAIN REPROCES EA TX SESS | Experimental/Investigational | Y | | | |
| 0483T | TMVI W PROSTHETIC VALVE PERCUTANEOUS APPROACH | Experimental/Investigational | Y | | | |
| 0484T | TMVI W PROSTHETIC VALVE TRANSTHORACIC EXPOSURE | Experimental/Investigational | Y | | | |
| 0488T | DIABETES PREV ONLINE ELECTRONIC PRGRM PR 30 DAYS | Experimental/Investigational | Y | | | |
| 0565T | AUTOL CELL IMPLT ADPS TISS HRVG CELL IMPLT CRTJ | Experimental/Investigational | Y | | | |
| 0566T | AUTOL CELL IMPLT ADPS TISS NJX IMPLT KNEE UNI | Experimental/Investigational | Y | | | |
| 0569T | TTVR PERCUTANEOUS APPROACH INITIAL PROSTHESIS | Experimental/Investigational | Y | | | |
| 0570T | TTVR PERCUTANEOUS APPROACH EACH ADDL PROSTHESIS | Experimental/Investigational | Y | | | |
| 0674T | LAPS INSJ NEW/RPLCMT PERM ISDSS AGMNTJ CAR FUNCJ | Experimental/Investigational | Y | | | |
| 0675T | LAPS INSJ NEW/RPLCMT LEAD PERM ISDSS 1ST LEAD | Experimental/Investigational | Y | | | |
| 0676T | LAPS INSJ NEW/RPLCMT LEAD PERM ISDSS EA ADL LEAD | Experimental/Investigational | Y | | | |
| 0677T | LAPS REPOS LEAD PERM ISDSS 1ST REPOSITIONED LEAD | Experimental/Investigational | Y | | | |
| 0678T | LAPS REPOS LEAD PERM ISDSS EA ADDL REPOS LEAD | Experimental/Investigational | Y | | | |
| 0679T | LAPAROSCOPIC REMOVAL LEAD PERM ISDSS | Experimental/Investigational | Y | | | |
| 0680T | INSJ/RPLCMT PULSE GENERATOR ONLY ISDSS | Experimental/Investigational | Y | | | |
| 0681T | RELOCATION PULSE GENERATOR ONLY ISDSS | Experimental/Investigational | Y | | | |
| 0682T | REMOVAL PULSE GENERATOR ONLY ISDSS | Experimental/Investigational | Y | | | |
| 0683T | PROGRAMMING DEVICE EVALUATION IN PERSON ISDSS | Experimental/Investigational | Y | | | |
| 0684T | PERIPROCEDURAL DEVICE EVALUATION IN PERSON ISDSS | Experimental/Investigational | Y | | | |
| 0685T | INTERROGATION DEVICE EVALUATION IN PERSON ISDSS | Experimental/Investigational | Y | | | |

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| 0719T | PST VERTEBRAL JOINT RPLCMT LUMBAR SPI SINGLE SGM | Experimental/Investigational | Y | | | |
| 0738T | TX PLANNING MAG FLD INDCTJ ABLTJ MAL PRST8 TISS | Experimental/Investigational | Y | | | |
| 0770T | VIRTUAL REALITY TECHNOLOGY TO ASSIST THERAPY | Experimental/Investigational | Y | | | |
| 0771T | VR PX DISSOC SVC SAME PHYS/QHP 1ST 15 MIN 5YR/> | Experimental/Investigational | Y | | | |
| 0772T | VR PX DISSOC SVC SAME PHYS/QHP EA ADDL 15 MIN | Experimental/Investigational | Y | | | |
| 0773T | VR PX DISSOC SVC OTH PHYS/QHP 1ST 15 MIN 5YR/> | Experimental/Investigational | Y | | | |
| 0774T | VR PX DISSOC SVC OTHER PHYS/QHP EA ADDL 15 MIN | Experimental/Investigational | Y | | | |
| 0776T | THERAPEUTIC INDUCTION OF INTRA-BRAIN HYPOTHERMIA | Experimental/Investigational | Y | | | |
| 0777T | R-T PRESSURE SENSING EPIDURAL GUIDANCE SYSTEM | Experimental/Investigational | Y | | | |
| 0778T | SMMG CNCRNT APPL IMU SNR MEAS ROM POST GAIT MUSC | Experimental/Investigational | Y | | | |
| 0779T | GI MYOELECTRICAL ACTIVITY STUDY STMCH-COLON I&R | Experimental/Investigational | Y | | | |
| 0781T | BRNCHSC RF DSTRJ PULM NRV BI MAINSTEM BRONCHI | Experimental/Investigational | Y | | | |
| 0782T | BRNCHSC RF DSTRJ PULM NRV UNI MAINSTEM BRONCHUS | Experimental/Investigational | Y | | | |
| 0783T | TC AURICULAR NSTIMJ SETUP CALIBRATION &PT EDUCAJ | Experimental/Investigational | Y | | | |
| 0793T | PERQ TCAT THRM ABLTJ NERVES INNERVATING P-ART | Experimental/Investigational | Y | | | |
| 0794T | PT SPEC ALG RANKING PHARMACOONCOLOGIC TX OPTIONS | Experimental/Investigational | Y | | | |
| 0795T | TCAT INSJ PERM DUAL CHAMBER LDLS PM COMPL SYS | Experimental/Investigational | Y | | | |
| 0796T | TCAT INSJ PERM 2CHMBR LDLS PM R ATR PM COMPNT D | Experimental/Investigational | Y | | | |
| 0797T | TCAT INSJ PERM 2CHMBR LDLS PM R VENTR PM COMPNT | Experimental/Investigational | Y | | | |
| 0798T | TCAT RMVL PERM DUAL CHAMBER LDLS PM COMPL SYS | Experimental/Investigational | Y | | | |
| 0799T | TCAT RMVL PERM 2CHMBR LDLS PM R ATR PM COMPNT | Experimental/Investigational | Y | | | |
| 0800T | TCAT RMVL PERM 2CHMBR LDLS PM R VENTR PM COMPNT | Experimental/Investigational | Y | | | |
| 0801T | TCAT RMVL&RPLCMT PERM 2CHMBR LDLS PM 2CHMBR SYS | Experimental/Investigational | Y | | | |
| 0802T | TCAT RMVL&RPLCMT PERM 2CHMBR LDLS PM R ATR CMPNT | Experimental/Investigational | Y | | | |
| 0803T | TCAT RMVL&RPLCMT PRM 2CHMBR LDLS PM R VNTR CMPNT | Experimental/Investigational | Y | | | |
| 0805T | TCAT SUPR&IVC PROSTC VLV IMPLTJ PERQ FEM VN APPR D | Experimental/Investigational | Y | | | |
| 0806T | TCAT SUPR&IVC PROSTC VLV IMPLTJ OPEN FEM VN APPR | Experimental/Investigational | Y | | | |
| 0868T | HIGH-RESOLUTION GASTRIC ELECTROPHYSIOLOGY MAPG | Experimental/Investigational | Y | | | |
| A4563 | RECTAL CNTRL SYS VAG INSRT LT USE ANY TYPE EA | Experimental/Investigational | Y | | | |
| C9784 | ENDO SLEEVE GASTRO W/TUBE | Experimental/Investigational | Y | | | |
| C9785 | ENDO OUTLET RESTRICT W/TUBE | Experimental/Investigational | Y | | | |
| K1007 | BLTRL HKAFO DEVC PWR INCL PELVC COMPNTS UP KNEE JOINTS | Experimental/Investigational | Y | | | |
| L8608 | MISC EXT COMP SPL ACSS FOR ARGUS II RET PROS SYS | Experimental/Investigational | Y | | | |
| 81120 | IDH1 COMMON VARIANTS | Genetic Counseling & Testing | Y | | | |
| 81121 | IDH2 COMMON VARIANTS | Genetic Counseling & Testing | Y | | | |
| 81161 | DMD DUPLICATION DELETION ANALYSIS | Genetic Counseling & Testing | Y | | | |
| 81162 | BRCA1 BRCA2 GENE ALYS FULL SEQ FULL DUP DEL ALYS | Genetic Counseling & Testing | Y | | | |
| 81163 | BRCA1 BRCA2 GENE ANALYSIS FULL SEQUENCE ANALYSIS | Genetic Counseling & Testing | Y | | | |
| 81164 | BRCA1 BRCA2 GENE ANALYSIS FULL DUP DEL ANALYSIS | Genetic Counseling & Testing | Y | | | |
| 81165 | BRCA1 GENE ANALYSIS FULL SEQUENCE ANALYSIS | Genetic Counseling & Testing | Y | | | |
| 81166 | BRCA1 GENE ANALYSIS FULL DUP DEL ANALYSIS | Genetic Counseling & Testing | Y | | | |
| 81167 | BRCA2 GENE ANALYSIS FULL DUP DEL ANALYSIS | Genetic Counseling & Testing | Y | | | |
| 81168 | CCND1/IGH TRANSLOCATION ALYS MAJOR BP QUAL AND QUAN | Genetic Counseling & Testing | Y | | | |
| 81171 | AFF2 GENE ANALYSIS EVAL DETECT ABNORMAL ALLELES | Genetic Counseling & Testing | Y | | | |
| 81172 | AFF2 GENE ANALYSIS CHARACTERIZATION OF ALLELES | Genetic Counseling & Testing | Y | | | |
| 81173 | AR GENE ANALYSIS FULL GENE SEQUENCE | Genetic Counseling & Testing | Y | | | |
| 81174 | AR GENE ANALYSIS KNOWN FAMILIAL VARIANT | Genetic Counseling & Testing | Y | | | |
| 81175 | ASXL1 GENE ANALYSIS FULL GENE SEQUENCE | Genetic Counseling & Testing | Y | | | |
| 81191 | NTRK1 TRANSLOCATION ANALYSIS | Genetic Counseling & Testing | Y | | | |
| 81194 | NTRK TRANSLOCATION ANALYSIS | Genetic Counseling & Testing | Y | | | |

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| 81201 | APC GENE ANALYSIS FULL GENE SEQUENCE | Genetic Counseling & Testing | Y | | | |
| 81203 | APC GENE ANALYSIS DUPLICATION DELETION VARIANTS | Genetic Counseling & Testing | Y | | | |
| 81212 | BRCA1 BRCA 2 GEN ALYS 185DELAG 5385INSC 6174DELT | Genetic Counseling & Testing | Y | | | |
| 81225 | CYP2C19 GENE ANALYSIS COMMON VARIANTS | Genetic Counseling & Testing | Y | | | |
| 81226 | CYP2D6 GENE ANALYSIS COMMON VARIANTS | Genetic Counseling & Testing | Y | | | |
| 81227 | CYP2C9 GENE ANALYSIS COMMON VARIANTS | Genetic Counseling & Testing | Y | | | |
| 81228 | CYTOGENOM CONST MICROARRAY COPY NUMBER VARIANTS | Genetic Counseling & Testing | Y | | | |
| 81229 | CYTOGENOM CONST MICROARRAY COPY NUMBER AND SNP VAR | Genetic Counseling & Testing | Y | | | |
| 81230 | CYP3A4 GENE ANALYSIS COMMON VARIANTS | Genetic Counseling & Testing | Y | | | |
| 81231 | CYP3A5 GENE ANALYSIS COMMON VARIANTS | Genetic Counseling & Testing | Y | | | |
| 81232 | DYPD GENE ANALYSIS COMMON VARIANTS | Genetic Counseling & Testing | Y | | | |
| 81233 | BTK GENE ANALYSIS COMMON VARIANTS | Genetic Counseling & Testing | Y | | | |
| 81235 | EGFR GENE ANALYSIS COMMON VARIANTS | Genetic Counseling & Testing | Y | | | |
| 81236 | EZH2 GENE ANALYSIS FULL GENE SEQUENCE | Genetic Counseling & Testing | Y | | | |
| 81237 | EZH2 GENE ANALYSIS COMMON VARIANTS | Genetic Counseling & Testing | Y | | | |
| 81239 | DMPK GENE ANALYSIS CHARACTERIZATION OF ALLELES | Genetic Counseling & Testing | Y | | | |
| 81246 | FLT3 GENE ANLYS TYROSINE KINASE DOMAIN VARIANTS | Genetic Counseling & Testing | Y | | | |
| 81249 | G6PD GENE ANALYSIS FULL GENE SEQUENCE | Genetic Counseling & Testing | Y | | | |
| 81272 | KIT GENE ANALYSIS TARGETED SEQUENCE ANALYSIS | Genetic Counseling & Testing | Y | | | |
| 81277 | CYTOGENOMIC NEOPLASIA MICROARRAY ANALYSIS | Genetic Counseling & Testing | Y | | | |
| 81292 | MLH1 GENE ANALYSIS FULL SEQUENCE ANALYSIS | Genetic Counseling & Testing | Y | | | |
| 81295 | MSH2 GENE ANALYSIS FULL SEQUENCE ANALYSIS | Genetic Counseling & Testing | Y | | | |
| 81298 | MSH6 GENE ANALYSIS FULL SEQUENCE ANALYSIS | Genetic Counseling & Testing | Y | | | |
| 81300 | MSH6 GENE ANALYSIS DUPLICATION DELETION VARIA | Genetic Counseling & Testing | Y | | | |
| 81306 | NUDT15 GENE ANALYSIS COMMON VARIANTS | Genetic Counseling & Testing | Y | | | |
| 81307 | PALB2 GENE ANALYSIS (FULL GENE SEQ) | Genetic Counseling & Testing | Y | | | |
| 81308 | PALB2 GENE ANALYSIS (KNOWN FAMILIAL VARIANT) | Genetic Counseling & Testing | Y | | | |
| 81309 | PIK3CA GENE ANALYSIS TARGETED SEQUENCE ANALYSIS | Genetic Counseling & Testing | Y | | | |
| 81311 | NRAS GENE ANALYSIS VARIANTS IN EXON 2 AND 3 | Genetic Counseling & Testing | Y | | | |
| 81314 | PDGFRA GENE ANALYS TARGETED SEQUENCE ANALYS | Genetic Counseling & Testing | Y | | | |
| 81317 | PMS2 GENE ANALYSIS FULL SEQUENCE | Genetic Counseling & Testing | Y | | | |
| 81321 | PTEN GENE ANALYSIS FULL SEQUENCE ANALYSIS | Genetic Counseling & Testing | Y | | | |
| 81323 | PTEN GENE ANALYSIS DUPLICATION DELETION VARIANT | Genetic Counseling & Testing | Y | | | |
| 81333 | TGFBI GENE ANALYSIS COMMON VARIANTS | Genetic Counseling & Testing | Y | | | |
| 81345 | TERT GENE ANALYSIS TARGETED SEQUENCE ANALYSIS | Genetic Counseling & Testing | Y | | | |
| 81351 | TP53 GENE ANALYSIS FULL GENE SEQUENCE | Genetic Counseling & Testing | Y | | | |
| 81403 | MOLECULAR PATHOLOGY PROCEDURE LEVEL 4 | Genetic Counseling & Testing | Y | | | |
| 81404 | MOLECULAR PATHOLOGY PROCEDURE LEVEL 5 | Genetic Counseling & Testing | Y | | | |
| 81405 | MOLECULAR PATHOLOGY PROCEDURE LEVEL 6 | Genetic Counseling & Testing | Y | | | |
| 81406 | MOLECULAR PATHOLOGY PROCEDURE LEVEL 7 | Genetic Counseling & Testing | Y | | | |
| 81407 | MOLECULAR PATHOLOGY PROCEDURE LEVEL 8 | Genetic Counseling & Testing | Y | | | |
| 81408 | MOLECULAR PATHOLOGY PROCEDURE LEVEL 9 | Genetic Counseling & Testing | Y | | | |
| 81410 | AORTIC DYSFUNCTION DILATION GENOMIC SEQ ANALYSIS | Genetic Counseling & Testing | Y | | | |
| 81411 | AORTIC DYSFUNCTION DILATION DUP DEL ANALYSIS | Genetic Counseling & Testing | Y | | | |
| 81412 | ASHKENAZI JEWISH ASSOC DSRDRS GEN SEQ ANAL 9 GEN | Genetic Counseling & Testing | Y | | | |
| 81413 | CAR ION CHNNLPATH GENOMIC SEQ ALYS INC 10 GNS | Genetic Counseling & Testing | Y | | | |
| 81414 | CAR ION CHNNLPATH DUP DEL GN ALYS PANEL 2 GENES | Genetic Counseling & Testing | Y | | | |
| 81415 | EXOME SEQUENCE ANALYSIS | Genetic Counseling & Testing | Y | | | |
| 81416 | EXOME SEQUENCE ANALYSIS EACH COMPARATOR EXOME | Genetic Counseling & Testing | Y | | | |

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|---|---|---|---|---|---|---|
| 81418 | DRG MTBLSM (EG, PHRMCGNOMCS) GNOMIC SQNC ANLYSS PANL, MUST INCLD TSTNG OF ATLEAST 6 GENES, NCLDNG CYP2C19, CYP2D6, ND CYP2D6 DPLCTN/DELETN ANLYSS | Genetic Counseling & Testing | Y | | | |
| 81419 | EPILEPSY GENOMIC SEQUENCE ANALYSIS PANEL | Genetic Counseling & Testing | Y | | | |
| 81422 | FETAL CHROMOSOMAL MICRODELTJ GENOMIC SEQ ANALYS | Genetic Counseling & Testing | Y | | | |
| 81425 | GENOME SEQUENCE ANALYSIS | Genetic Counseling & Testing | Y | | | |
| 81426 | GENOME SEQUENCE ANALYSIS EACH COMPARATOR GENOME | Genetic Counseling & Testing | Y | | | |
| 81427 | GENOME RE-EVALUATION OF PREC OBTAINED GENOME SEQ | Genetic Counseling & Testing | Y | | | |
| 81430 | HEARING LOSS GENOMIC SEQUENCE ANALYSIS 60 GENES | Genetic Counseling & Testing | Y | | | |
| 81431 | HEARING LOSS DUP DEL ANALYSIS | Genetic Counseling & Testing | Y | | | |
| 81432 | HEREDITARY BRST CA-RELATED GEN SEQ ANALYS 10 GEN | Genetic Counseling & Testing | Y | | | |
| 81434 | HEREDITARY RETINAL DSRDRS GEN SEQ ANALYS 15 GEN | Genetic Counseling & Testing | Y | | | |
| 81435 | HEREDITARY COLON CA DSRDRS GEN SEQ ANALYS 10 GEN | Genetic Counseling & Testing | Y | | | |
| 81437 | HEREDTRY NURONDCRN TUM DSRDRS GEN SEQ ANAL 6 GEN | Genetic Counseling & Testing | Y | | | |
| 81439 | HEREDITARY CARDIOMYOPATHY GEN SEQ ANALYS 5 GEN | Genetic Counseling & Testing | Y | | | |
| 81440 | NUCLEAR MITOCHONDRIAL 100 GENE GENOMIC SEQ | Genetic Counseling & Testing | Y | | | |
| 81441 | BMFS SEQUENCE ANALYSIS PANEL AT LEAST 30 GENES | Genetic Counseling & Testing | Y | | | |
| 81443 | GENETIC TESTING FOR SEVERE INHERITED CONDITIONS | Genetic Counseling & Testing | Y | | | |
| 81445 | GEN SEQ ANALYS SOLID ORGAN NEOPLASM 5-50 GENE | Genetic Counseling & Testing | Y | | | |
| 81448 | HEREDITARY PERIPHERAL NEUROPATHY GEN SEQ PNL | Genetic Counseling & Testing | Y | | | |
| 81449 | TRGTD GNMIC SQNC ANLYSS PANEL, SOLID ORGN NPLSM, 5-50 GENES (EG, ALK, BRAF, CDKN2A, EGFR, ERBB2, KIT, KRAS, MET, NRAS, PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET), INTRRGTION FOR SQNC VRNTS AND COPY NMBR VRNTS OR REARRNGMNTS, IF PRFRMD; RNA ANLYSS | Genetic Counseling & Testing | Y | | | |
| 81450 | GEN SEQ ANALYS HEMATOLYMPHOID NEO 5-50 GENE | Genetic Counseling & Testing | Y | | | |
| 81451 | TGSAP HEMATOLYMPHOID NEO/DO 5-50 RNA ANALYSIS | Genetic Counseling & Testing | Y | | | |
| 81455 | GEN SEQ ANALYS SOL ORG HEMTOLMPHOID NEO 51 OR GRT GEN | Genetic Counseling & Testing | Y | | | |
| 81456 | TGSAP SO/HEMATOLYMPHOID NEO/DO 51 OR LT RNA ANALYSIS | Genetic Counseling & Testing | Y | | | |
| 81460 | WHOLE MITOCHONDRIAL GENOME | Genetic Counseling & Testing | Y | | | |
| 81465 | WHOLE MITOCHONDRIAL GENOME ANALYSIS PANEL | Genetic Counseling & Testing | Y | | | |
| 81470 | X-LINKED INTELLECTUAL DBLT GENOMIC SEQ ANALYS | Genetic Counseling & Testing | Y | | | |
| 81471 | X-LINKED INTELLECTUAL DBLT DUP DEL GENE ANALYS | Genetic Counseling & Testing | Y | | | |
| 81479 | UNLISTED MOLECULAR PATHOLOGY PROCEDURE | Genetic Counseling & Testing | Y | | | |
| 81493 | COR ART DISEASE MRNA GENE EXPRESSION 23 GENES | Genetic Counseling & Testing | Y | | | |
| 81503 | ONCO (OVARIAN) BIOCHEMICAL ASSAY FIVE PROTEINS | Genetic Counseling & Testing | Y | | | |
| 81504 | ONCOLOGY TISSUE OF ORIGIN SIMILAR SCOR ALGORITHM | Genetic Counseling & Testing | Y | | | |
| 81518 | ONCOLOGY BREAST MRNA GENE EXPRESSION 11 GENES | Genetic Counseling & Testing | Y | | | |
| 81519 | ONCOLOGY BREAST MRNA GENE EXPRESSION 21 GENES | Genetic Counseling & Testing | Y | | | |
| 81520 | ONC BREAST MRNA GENE XPRSN PRFL HYBRD 58 GENES | Genetic Counseling & Testing | Y | | | |
| 81521 | ONC BREAST MRNA MICRORA GENE XPRSN PRFL 70 GENES | Genetic Counseling & Testing | Y | | | |
| 81522 | ONCOLOGY BREAST MRNA GENE XPRSN PRFL 12 GENES | Genetic Counseling & Testing | Y | | | |
| 81523 | ONC BRST MRNA NEXT GNRJ SEQ GEN XPRSN 70 CNT AND 31 | Genetic Counseling & Testing | Y | | | |
| 81525 | ONCOLOGY COLON MRNA GENE EXPRESSION 12 GENES | Genetic Counseling & Testing | Y | | | |
| 81529 | ONC CUTAN MLNMA MRNA GENE XPRS PRFL 31 GENES ALG | Genetic Counseling & Testing | Y | | | |
| 81535 | ONCOLOGY GYNE LIVE TUM CELL CLTR AND CHEMO RESP 1ST | Genetic Counseling & Testing | Y | | | |
| 81536 | ONCOLOGY GYNE LIVE TUM CELL CLTR AND CHEMO RESP ADD | Genetic Counseling & Testing | Y | | | |
| 81538 | ONCOLOGY LUNG MS 8-PROTEIN SIGNATURE | Genetic Counseling & Testing | Y | | | |
| 81540 | ONCOLOGY TUM UNKNOWN ORIGIN MRNA 92 GENES | Genetic Counseling & Testing | Y | | | |
| 81541 | ONC PROSTATE MRNA GENE XPRSN PRFL RT-PCR 46 GENES | Genetic Counseling & Testing | Y | | | |

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| 81542 | ONC PROSTATE MRNA MICRORA GENE XPRSN PRFL 22 GENES | Genetic Counseling & Testing | Y | | | |
| 81546 | ONC THYR MRNA 10,196 GENES FINE NDL ASPIRATE ALG | Genetic Counseling & Testing | Y | | | |
| 81551 | ONC PROSTATE PRMTR METHYLATION PRFL R-T PCR 3 GENES | Genetic Counseling & Testing | Y | | | |
| 81552 | ONC UVEAL MLNMA MRNA GENE XPRSN PRFL 15 GENES | Genetic Counseling & Testing | Y | | | |
| 81554 | PULM DS IPF MRNA 190 GENE TRANSBRONCHIAL BX ALG | Genetic Counseling & Testing | Y | | | |
| 81595 | CARDIOLOGY HRT TRNSPL MRNA GENE EXPRESS 20 GENES | Genetic Counseling & Testing | Y | | | |
| 81599 | UNLISTED MULTIANALYTE ASSAY ALGORITHMIC ANALYSIS | Genetic Counseling & Testing | Y | | | |
| 0005U | ONCO PROSTATE GENE XPRS PRFL 3 GENE UR ALG RSK SCOR | Genetic Counseling & Testing | Y | | | |
| 0006M | ONCOLOGY HEP MRNA 161 GENES RISK CLASSIFIER | Genetic Counseling & Testing | Y | | | |
| 0007M | ONCOLOGY GASTRO 51 GENES NOMOGRAM DISEASE INDEX | Genetic Counseling & Testing | Y | | | |
| 0009U | ONC BRST CA ERBB2 COPY NUMBER FISH AMP NONAMP | Genetic Counseling & Testing | Y | | | |
| 0022U | TRGT GEN SEQ ALYS NONSM LNG NEO DNA AND RNA 23 GENES | Genetic Counseling & Testing | Y | | | |
| 0037U | TRGT GEN SEQ ALYS SLD ORGN NEO DNA 324 GENES | Genetic Counseling & Testing | Y | | | |
| 0047U | ONC PROSTATE MRNA GEN XPRS PRFL 17 GEN ALG RSK SCOR | Genetic Counseling & Testing | Y | | | |
| 0070U | CYP2D6 GENE ANALYSIS COMMON AND SELECT RARE VRNTS | Genetic Counseling & Testing | Y | | | |
| 0140U | NFCT DS FUNGAL PATHOGEN ID DNA 15 FUNGAL TARGETS | Genetic Counseling & Testing | Y | | | |
| 0152U | NFCT DS BCT FNG PARASITE DNA VIR DETCJ OVER 1000 ORG | Genetic Counseling & Testing | Y | | | |
| 0153U | ONC BREAST MRNA GENE EXPRESSION PRFL 101 GENES | Genetic Counseling & Testing | Y | | | |
| 0154U | ONC UROTHELIAL CANCER RNA RT-PCR FGFR3 GENE ALYS | Genetic Counseling & Testing | Y | | | |
| 0155U | ONC BRST CA DNA PIK3CA GENE ALYS BRST TUM TISS | Genetic Counseling & Testing | Y | | | |
| 0172U | ONC SLD TUM ALYS BRCA1 BRCA2 | Genetic Counseling & Testing | Y | | | |
| 0173U | PSYC GEN ALYS PANEL 14 GENES | Genetic Counseling & Testing | Y | | | |
| 0174U | OC SLD TUMOR 30 PRTN TRGT | Genetic Counseling & Testing | Y | | | |
| 0175U | PSYC GEN ALYS PANEL 15 GENES | Genetic Counseling & Testing | Y | | | |
| 0179U | ONC NONSM CLL LNG CA ALYS 23 | Genetic Counseling & Testing | Y | | | |
| 0184U | DO GNOTYP ART4 EXON 2 | Genetic Counseling & Testing | Y | | | |
| 0196U | LU GNOTYP BCAM EXON 3 | Genetic Counseling & Testing | Y | | | |
| 0209U | CYTOG CONST ALYS INTERROG | Genetic Counseling & Testing | Y | | | |
| 0215U | RARE DS XOM DNA ALYS EA COMP | Genetic Counseling & Testing | Y | | | |
| 0216U | NEURO INH ATAXIA DNA 12 COM | Genetic Counseling & Testing | Y | | | |
| 0217U | NEURO INH ATAXIA DNA 51 GENE | Genetic Counseling & Testing | Y | | | |
| 0218U | NEURO MUSC DYS DMD SEQ ALYS | Genetic Counseling & Testing | Y | | | |
| 0239U | TRGT GEN SEQ ALYS SLD ORGN NEO CLL-FR DNA 311 PLUS | Genetic Counseling & Testing | Y | | | |
| 0326U | TRGT GEN SEQ ALYS SLD ORGN NEO CLL-FR DNA 83 PLUS | Genetic Counseling & Testing | Y | | | |
| 0327U | FTL ANEUPLOIDY TRSMY DNA SEQ ALYS MAT PLSM RSK | Genetic Counseling & Testing | Y | | | |
| 0387U | ONC MLNMA AMBRA1&LORICRIN IMHCHEM FFPE TISS | Genetic Counseling & Testing | Y | | | |
| 0388U | ONC NONSM CLL LNG CA NXT GNRJ SEQ 37 CA RLTD GEN | Genetic Counseling & Testing | Y | | | |
| 0389U | PED FEBRILE ILNES KAWASAKI DS IFI27&MCEP1 RNA | Genetic Counseling & Testing | Y | | | |
| 0390U | OB PREECLAMPSIA KDR ENDOGLIN&RBP4 IA SRM ALG | Genetic Counseling & Testing | Y | | | |
| 0391U | ONC SLD TUM DNA&RNA NXT GNJ SEQ FFPE TISS 437 | Genetic Counseling & Testing | Y | | | |
| 0392U | RX METAB GEN-RX IA VRNT ALYS 16 GENES CYP2D6 | Genetic Counseling & Testing | Y | | | |
| 0393U | NEURO PRKNSN CSF DETCJ MSFLD A-SYNCLN PRTN QUAL | Genetic Counseling & Testing | Y | | | |
| 0394U | PFAS 16 PFAS COMPND LC MS/MS PLSM/SRM QUAN | Genetic Counseling & Testing | Y | | | |
| 0395U | ONC LUNG MULTIOMICS PLASMA ALG MAL RISK LNG NDUL | Genetic Counseling & Testing | Y | | | |
| 0398U | GI BARRETT ESOPH DNA MTHYLTN ALYS ALG DYSP/CA | Genetic Counseling & Testing | Y | | | |
| 0399U | U NEURO CEREBRAL FOLATE DEFICIENCY SERUM QUAN | Genetic Counseling & Testing | Y | | | |
| 0400U | OB XPND CAR SCR 145 GEN NXT GNRJ SEQ FRAG ALYS | Genetic Counseling & Testing | Y | | | |
| 0401U | CRD C HRT DS 9 GEN 12 VRNTS TRGT VRNT GNOTYP ALG | Genetic Counseling & Testing | Y | | | |
| 0402U | NFCT AGT STI MULT AMP PRB TQ VAG ENDOCRV/MALE UR | Genetic Counseling & Testing | Y | | | |
| 0403U | ONC PRST8 MRNA GEN XPRSN PRFLG 18GENS 1-CATCH UR | Genetic Counseling & Testing | Y | | | |

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|---|---|---|---|---|---|---|
| 0404U | ONC BRST CA SEMIQ MEAS THYMIDINE KINASE ACTV IA | Genetic Counseling & Testing | Y | | | |
| 0405U | ONC PNCRTC 59 MTHYLTN HAPLOTYPE BLOCK MRK PLSM | Genetic Counseling & Testing | Y | | | |
| 0406U | ONC LUNG FLOW CYTOMETRY SPUTUM 5 MARKERS ALG | Genetic Counseling & Testing | Y | | | |
| 0407U | NEPHROLOGY DIABETIC CKD MULT ECLIA PLASMA ALG | Genetic Counseling & Testing | Y | | | |
| 0409U | ONC SLD TUM DNA 80&RNA 36 GEN NEXT GNRJ SEQ PLSM | Genetic Counseling & Testing | Y | | | |
| 0410U | ONC PNCRTC DNA WHL GN SEQ 5- HYDROXYMETHYLCYTO SN | Genetic Counseling & Testing | Y | | | |
| 0411U | PSYC GENOMIC ALYS PANEL VARIANT ALYS 15 GENES | Genetic Counseling & Testing | Y | | | |
| 0412U | BETA AMYLOID AB42/40 IMPRCIP QUAN LCMS/MS ALG | Genetic Counseling & Testing | Y | | | |
| 0413U | ONC HL NEO OPT GEN MAPG CPY NMBR ALTERATIONS DNA | Genetic Counseling & Testing | Y | | | |
| 0414U | ONC LUNG AUGMNT ALG ALYS DGTZ WHOL SLD IMG 8 GEN | Genetic Counseling & Testing | Y | | | |
| 0415U | CV DS ACS IA ALG BLOOD 5 YEAR DEL RISK SCORE ACS | Genetic Counseling & Testing | Y | | | |
| 0417U | RARE DS WHL MITOCHDRL GEN SEQ ALYS 335 NUC GENES | Genetic Counseling & Testing | Y | | | |
| 0418U | ONC BRST AUGMNT ALG ALYS DGTZ WHOL SLD IMG 8FEAT | Genetic Counseling & Testing | Y | | | |
| 0419U | NEUROPSYCHIATRY GEN SEQ ALYS PNL VRNT ALY 13 GEN | Genetic Counseling & Testing | Y | | | |
| 90281 | IMMUNE GLOBULIN IG HUMAN IM USE | Healthcare Administered Drugs | Y | | | |
| 90283 | IMMUNE GLOBULIN IGIV HUMAN IV USE | Healthcare Administered Drugs | Y | | | |
| 90284 | IMMUNE GLOBULIN HUMAN SUBQ INFUSION 100 MG EA | Healthcare Administered Drugs | Y | | | |
| 90291 | CYTOMEGALOVIRUS IMMUNE GLOBULIN HUMAN IV | Healthcare Administered Drugs | Y | | | |
| 90371 | HEPATITIS B IMMUNE GLOBULIN HBIG HUMAN IM | Healthcare Administered Drugs | Y | | | |
| 90378 | RESPIRATORY SYNCYTIAL VIRUS IG IM 50 MG E | Healthcare Administered Drugs | Y | | | |
| C9306 | TELISOTUZUMAB VEDOTIN-TLLV | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | |
| A9596 | GALLIUM GA -68GOZETOTIDE, DIAGNOSTIC, (ILLUCCIX), 1 MILLICURIE | Healthcare Administered Drugs | Y | | | |
| A9601 | FLORTAUCIPIR -18INJECTION, DIAGNOSTIC, 1 MILLICURIE | Healthcare Administered Drugs | Y | | | |
| A9607 | LUTETIUM LU 177 VIPIVOTIDE TETRAXETAN THER 1 MCI | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| B4187 | OMEGAVEN, 10 G LIPIDS | Healthcare Administered Drugs | Y | | | |
| B4199 | PARNTRAL NUT SOL; AMINO ACID and CARB GT 100 GMS PPAR | Healthcare Administered Drugs | Y | | | |
| C9047 | INJECTION CAPLACIZUMAB-YHDP 1 MG | Healthcare Administered Drugs | Y | | | |
| C9145 | INJ, APONVIE, 1 MG | Healthcare Administered Drugs | Y | | | |
| C9173 | INJ, NYPOZI, 1 MCG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | |
| C9257 | INJECTION BEVACIZUMAB 0.25 MG | Healthcare Administered Drugs | Y | | Bevacizumab when billed for intraocular injection does not require a PA | |
| C9293 | INJECTION GLUCARPIDASE 10 UNITS | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| C9305 | INJ, NIPOCALIMAB-AAHU, 3 MG | Healthcare Administered Drugs | Y | | | |
| C9399 | UNCLASSIFIED DRUGS OR BIOLOGICALS | Healthcare Administered Drugs | Y | | | |
| C9488 | INJECTION CONIVAPTAN HYDROCHLORIDE 1 MG | Healthcare Administered Drugs | Y | | | |
| J0121 | INJECTION OMADACYCLINE 1 MG | Healthcare Administered Drugs | Y | | | |
| J0122 | INJECTION, ERAVACYCLINE, 1 MG | Healthcare Administered Drugs | Y | | | |
| J0129 | INJ ABATACEPT 10 MG USED MEDICARE ADM SUPV PHYS | Healthcare Administered Drugs | Y | | | |

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|---|---|---|---|---|---|---|
| J0139 | INJ, ADALIMUMAB, 1 MG | Healthcare Administered Drugs | Y | | | |
| J0172 | INJECTION, ADUCANUMAB-AVWA, 2MG | Healthcare Administered Drugs | Y | | | |
| J0174 | INJ, LECANEMAB-IRMB, 1 MG | Healthcare Administered Drugs | Y | | | |
| J0175 | INJ, DONANEMAB-AZBT, 2 MG | Healthcare Administered Drugs | Y | | | |
| J0177 | INJECTION, AFLIBERCEPT HD, 1 MG | Healthcare Administered Drugs | Y | | | |
| J0178 | INJECTION AFLIBERCEPT 1 MG | Healthcare Administered Drugs | Y | | | |
| J0179 | INJECTION, BROLUCIZUMAB-DBLL, 1MG | Healthcare Administered Drugs | Y | | | |
| J0180 | INJECTION AGALSIDASE BETA 1 MG | Healthcare Administered Drugs | Y | | | |
| J0185 | INJ., APREPITANT, 1MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J0202 | INJECTION ALEMTUZUMAB 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | |
| J0207 | INJECTION AMIFOSTINE 500 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J0208 | INJECTION, SODIUM THIOSULFATE, 100 MG | Healthcare Administered Drugs | Y | | | |
| J0209 | INJECTION, SODIUM THIOSULFATE (HOPE), 100 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | |
| J0217 | INJ, VELMANASE ALFA-TYCV, 1 MG | Healthcare Administered Drugs | Y | | | |
| J0218 | INJECTION, OLIPUDASE ALFA-RPCP, 1 MG | Healthcare Administered Drugs | Y | | | |
| J0219 | INJECTION AVALGLUCOSIDASE ALFA-NGPT 4 MG | Healthcare Administered Drugs | Y | | | |
| J0221 | INJECTION ALGLUCOSIDASE ALFA LUMIZYME 10 MG | Healthcare Administered Drugs | Y | | | |
| J0222 | INJECTION PATISIRAN 0.1 MG | Healthcare Administered Drugs | Y | | | |
| J0223 | INJECTION, GIVOSIRAN, 0.5 MG | Healthcare Administered Drugs | Y | | | |
| J0224 | INJ. LUMASIRAN, 0.5 MG | Healthcare Administered Drugs | Y | | | |
| J0225 | INJ, VUTRISIRAN, 1 MG | Healthcare Administered Drugs | Y | | | |
| J0248 | INJ, REMDESIVIR, 1 MG | Healthcare Administered Drugs | Y | | | |
| J0256 | INJECTION ALPHA 1-PROTASE INHIBITOR NOS 10 MG | Healthcare Administered Drugs | Y | | | |
| J0257 | INJECTION ALPHA 1 PROTEINASE INHIBITOR 10 MG | Healthcare Administered Drugs | Y | | | |
| J0291 | INJECTION PLAZOMICIN 5 MG | Healthcare Administered Drugs | Y | | | |
| J0349 | INJECTION, REZAFUNGIN, 1 MG | Healthcare Administered Drugs | Y | | | |
| J0364 | INJECTION APOMORPHINE HYDROCHLORIDE 1 MG | Healthcare Administered Drugs | Y | | | |
| J0458 | INJ, AZTREONAM/AVIBACTAM, 7.5 MG/2.5 MG (10 MG) | Healthcare Administered Drugs | Y | | | |
| J0480 | INJECTION BASILIXIMAB 20 MG | Healthcare Administered Drugs | Y | | | |
| J0485 | INJECTION BELATACEPT 1 MG | Healthcare Administered Drugs | Y | | | |
| J0490 | INJECTION BELIMUMAB 10 MG | Healthcare Administered Drugs | Y | | | |
| J0491 | INJECTION ANIFROLUMAB-FNIA 1 MG | Healthcare Administered Drugs | Y | | | |
| J0517 | INJECTION BENRALIZUMAB 1 MG | Healthcare Administered Drugs | Y | | | |
| J0565 | INJECTION BEZLOTOXUMAB 10 MG | Healthcare Administered Drugs | Y | | | |
| J0567 | INJECTION CERLIPONASE ALFA 1 MG | Healthcare Administered Drugs | Y | | | |
| J0584 | INJECTION BUROSUMAB-TWZA 1 MG | Healthcare Administered Drugs | Y | | | |
| J0585 | BOTULINUM TOXIN TYPE A PER UNIT | Healthcare Administered Drugs | Y | | | |
| J0586 | INJECTION ABOBOTULINUMTOXINA 5 UNITS | Healthcare Administered Drugs | Y | | | |

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|---|---|---|---|---|---|---|
| J0587 | INJECTION RIMABOTULINUMTOXINB 100 UNITS | Healthcare Administered Drugs | Y | | | |
| J0588 | INJECTION INCOBOTULINUMTOXIN A 1 UNIT | Healthcare Administered Drugs | Y | | | |
| J0589 | INJECTION, DAXIBOTULINUMTOXINA-LANM, 1 UNIT | Healthcare Administered Drugs | Y | | | |
| J0593 | INJECTION, LANADELUMAB-FLYO 1 MG | Healthcare Administered Drugs | Y | | | |
| J0596 | INJECTION C1 ESTERASE INHIBITOR RUCONEST 10 U | Healthcare Administered Drugs | Y | | | |
| J0597 | INJ C-1 ESTERASE INHIB HUMN BERINERT 10 UNITS | Healthcare Administered Drugs | Y | | | |
| J0598 | INJECTION C1 ESTERASE INHIBITOR CINRYZE 10 UNITS | Healthcare Administered Drugs | Y | | | |
| J0599 | INJECTION C-1 ESTERASE INHIBITOR 10 UNITS | Healthcare Administered Drugs | Y | | | |
| J0601 | SEVELAMER CARBONATE 20 MG | Healthcare Administered Drugs | NC | | Services covered through pharmacy benefit. | |
| J0602 | SEVELAMER CARBONATE PDR 20MG | Healthcare Administered Drugs | NC | | Services covered through pharmacy benefit. | |
| J0603 | SEVELAMER HYDROCHLORIDE 20MG | Healthcare Administered Drugs | NC | | Services covered through pharmacy benefit. | |
| J0604 | CINACALCET ORAL 1 MG | Healthcare Administered Drugs | Y | | | |
| J0605 | SUCROFERRIC OXYHYDROXIDE 5MG | Healthcare Administered Drugs | NC | | Services covered through pharmacy benefit. | |
| J0606 | INJECTION ETELCALCETIDE 0.1 MG | Healthcare Administered Drugs | Y | | | |
| J0607 | LANTHANUM CARBONATE ORAL 5MG | Healthcare Administered Drugs | NC | | Services covered through pharmacy benefit. | |
| J0608 | LANTHANUM CARBONATE PWDR 5MG | Healthcare Administered Drugs | NC | | Services covered through pharmacy benefit. | |
| J0609 | FERRIC CITRATE ORL 3 MG IRON | Healthcare Administered Drugs | NC | | Services covered through pharmacy benefit. | |
| J0614 | INJ, TREOSULFAN, 50 MG | Healthcare Administered Drugs | Y | | | |
| J0615 | CALCIUM ACETATE, ORAL, 23 MG | Healthcare Administered Drugs | NC | | Services covered through pharmacy benefit. | |
| J0630 | CALCITONIN SALMON INJECTION | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | |
| J0638 | INJECTION CANAKINUMAB 1 MG | Healthcare Administered Drugs | Y | | | |
| J0641 | INJECTION LEVOLEUCOVORIN CALCIUM 0.5 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J0642 | INJECTION LEVOLEUCOVORIN (KHAPZORY), 0.5 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J0681 | INJ, CEFTOBIPROLE MEDOCARIL SODIUM, 3 MG | Healthcare Administered Drugs | Y | | | |
| J0695 | INJECTION CEFTOLOZANE 50 MG AND TAZOBACTAM 25 MG | Healthcare Administered Drugs | Y | | | |
| J0699 | INJECTION, CEFIDEROCOL, 10 MG | Healthcare Administered Drugs | Y | | Bevacizumab when billed for intraocular injection does not require a PA | |
| J0712 | INJECTION, CEFTAROLINE FOSAMIL, 10 MG | Healthcare Administered Drugs | Y | | | |
| J0714 | INJECTION CEFTAZIDIME AND AVIBACTAM 0.5 G 0.125 G | Healthcare Administered Drugs | Y | | | |
| J0717 | INJECTION CERTOLIZUMAB PEGOL 1 MG | Healthcare Administered Drugs | Y | | | |
| J0725 | INJECTION CHORIONIC GONADOTROPIN-1000 USP UNITS | Healthcare Administered Drugs | Y | | | |
| J0739 | INJECTION, CABOTEGRAVIR, 1 MG | Healthcare Administered Drugs | Y | | | |
| J0741 | INJECTION, CABOTEGRAVIR AND RILPIVIRINE, 2 MG/3 MG | Healthcare Administered Drugs | Y | | Bevacizumab when billed for intraocular injection does not require a PA | |
| J0750 | HIV PREP, FTC/TDF 200/300MG | Healthcare Administered Drugs | NC | | HIV pre-exposure prophylaxis that is self-administered is only covered under the pharmacy benefit. See plan drug list for coverage details. | |
| J0751 | HIV PREP, FTC/TAF 200/25MG | Healthcare Administered Drugs | NC | | HIV pre-exposure prophylaxis that is self-administered is only covered under the pharmacy benefit. See plan drug list for coverage details. | |
| J0775 | INJ COLLAGENASE CLOSTRIDIUM HISTOLYTICUM 0.01 MG | Healthcare Administered Drugs | Y | | | |
| J0791 | INJECTION, CRIZANLIZUMAB-TMCA, 5 MG | Healthcare Administered Drugs | Y | | | |
| J0799 | HIV PREP, FDA APPROVED, NOC | Healthcare Administered Drugs | NC | | HIV pre-exposure prophylaxis that is self-administered is only covered under the pharmacy benefit. See plan drug list for coverage details. | |
| J0801 | INJECTION, CORTICOTROPIN (ACTHAR GEL), UP TO 40 UNITS | Healthcare Administered Drugs | Y | | | |

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| J0802 | INJECTION, CORTICOTROPIN (ANI), UP TO 40 UNITS | Healthcare Administered Drugs | Y | | | |
| J0850 | INJECTION CYTOMEGALOVIRUS IMMUNE GLOB IV-VIAL | Healthcare Administered Drugs | Y | | | |
| J0870 | INJ, IMETELSTAT, 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J0872 | INJ, DAPTOMYCIN (XELLIA), UNREFRIGERATED, NOT THERAPEUTICALLY EQUIVALENT TO J0878 OR J0873, 1 MG | Healthcare Administered Drugs | Y | | | |
| J0873 | INJ, DAPTOMYCIN (XELLIA) NOT THERAPEUTICALLY EQUIVALENT TO J0878, 1 MG | Healthcare Administered Drugs | Y | | | |
| J0874 | INJECTION, DAPTOMYCIN (BAXTER), NOT THERAPEUTICALLY EQUIVALENT TO J0878, 1 MG | Healthcare Administered Drugs | Y | | | |
| J0875 | INJECTION DALBAVANCIN 5MG | Healthcare Administered Drugs | Y | | | |
| J0877 | INJ, DAPTOMYCIN (HOSPIRA) | Healthcare Administered Drugs | Y | | | |
| J0878 | INJECTION DAPTOMYCIN 1 MG | Healthcare Administered Drugs | Y | | | |
| J0879 | INJECTION DIFELIKEFALIN 0.1 MICROGRAM | Healthcare Administered Drugs | Y | | | |
| J0881 | INJECTION DARBEPOETIN ALFA 1 MCG NON-ESRD USE | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J0885 | INJECTION EPOETIN ALFA FOR NON-ESRD 1000 UNITS | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J0888 | INJECTION EPOETIN BETA 1 MICROGRAM | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J0889 | DAPRODUSTAT, ORAL, 1 MG, (FOR ESRD ON DIALYSIS) | Healthcare Administered Drugs | Y | | | |
| J0893 | INJ, DECITABINE (SUN PHARMA) | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J0894 | INJECTION DECITABINE 1 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J0896 | INJECTION, LUPATERCEPT-AAMT, 0.25 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J0897 | INJECTION DENOSUMAB 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J0901 | VADADUSTAT, ORAL, 1 MG (FOR ESRD ON DIALYSIS) | Healthcare Administered Drugs | Y | | | |
| J0911 | INSTILLATION, TAUROLIDINE 1.35 MG AND HEPARIN SODIUM 100 UNITS (CENTRAL VENOUS CATHETER LOCK FOR ESRD ON DIALYSIS) | Healthcare Administered Drugs | Y | | | |
| J1095 | INJECTION DEXAMETHASONE 9PCT INTRAOCULAR 1 MCG | Healthcare Administered Drugs | Y | | | |
| J1096 | DEXAMETHASONE LACRIMAL OPHTHALMIC INSERT 0.1 MG | Healthcare Administered Drugs | Y | | | |

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| J1105 | DEXMEDETOMIDINE, ORAL, 1 MCG | Healthcare Administered Drugs | Y | | | |
| J1190 | INJECTION DEXRAZOXANE HYDROCHLORIDE PER 250 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J1202 | MIGLUSTAT, ORAL, 65 MG | Healthcare Administered Drugs | Y | | | |
| J1203 | INJECTION, CIPAGLUCOSIDASE ALFA-ATGA, 5 MG | Healthcare Administered Drugs | Y | | | |
| J1290 | INJECTION ECALLANTIDE 1 MG | Healthcare Administered Drugs | Y | | | |
| J1299 | INJ, ECULIZUMAB, 2 MG | Healthcare Administered Drugs | Y | | | |
| J1301 | INJECTION EDARAVONE 1 MG | Healthcare Administered Drugs | Y | | | |
| J1302 | INJ SUTIMLIMAB-JOME 10 MG | Healthcare Administered Drugs | Y | | | |
| J1303 | INJECTION RAVULIZUMAB-CWVZ 10 MG | Healthcare Administered Drugs | Y | | | |
| J1304 | INJ, TOFERSEN, 1 MG | Healthcare Administered Drugs | Y | | | |
| J1305 | INJECTION, EVINACUMAB-DGNB, 5 MG | Healthcare Administered Drugs | Y | | | |
| J1306 | INJECTION, INCLISIRAN, MG | Healthcare Administered Drugs | Y | | | |
| J1307 | INJ, CROVALIMAB-AKKZ, 10 MG | Healthcare Administered Drugs | Y | | | |
| J1322 | INJECTION ELOSULFASE ALFA 1 MG | Healthcare Administered Drugs | Y | | | |
| J1323 | INJECTION, ELRANATAMAB-BCMM, 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J1325 | INJECTION EPOPROSTENOL 0.5 MG | Healthcare Administered Drugs | Y | | | |
| J1326 | INJ ZOLBETUXIMAB, 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J1426 | INJECTION, CASIMERSEN, 10 MG | Healthcare Administered Drugs | Y | | | |
| J1427 | INJECTION, VILTOLARSEN, 10 MG | Healthcare Administered Drugs | Y | | | |
| J1428 | INJECTION ETEPLIRSEN 10 MG | Healthcare Administered Drugs | Y | | | |
| J1429 | INJECTION, GOLODIRSEN, 10 MG | Healthcare Administered Drugs | Y | | | |
| J1434 | INJECTION, FOSAPREPITANT (FOCINVEZ), 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J1437 | INJECTION, FERRIC DERISOMALTOSE, 10MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J1438 | INJECTION ETANERCEPT 25 MG | Healthcare Administered Drugs | Y | | | |
| J1439 | INJECTION FERRIC CARBOXYMALTOSE 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J1440 | FECAL MICROBIOTA, LIVE - JSLM, 1 ML | Healthcare Administered Drugs | Y | | | |
| J1442 | INJECTION FILGRASTIM EXCLUDES BIOSIMILARS 1 MIC | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |

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| J1447 | INJECTION TBO-FILGRASTIM 1 MICROGRAM | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J1448 | INJECTION, TRILACICLIB, 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J1449 | INJECTION, EFLAPEGRASTIM-XNST, 0.1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J1454 | INJ FOSNETUPITANT 235 MG AND PALONOSETRON 0.25 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J1456 | INJECTION, FOSAPREPITANT (TEVA), NOT THERAPEUTICALLY EQUIVALENT TO J1453, 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J1458 | INJECTION GALSULFASE 1 MG | Healthcare Administered Drugs | Y | | | |
| J1459 | INJ IMMUNE GLOBULIN IV NONLYOPHILIZED 500 MG (PRIVIGEN) | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | |
| J1460 | INJECTION GAMMA GLOBULIN INTRAMUSCULAR 1 CC | Healthcare Administered Drugs | Y | | | |
| J1551 | INJECTION, IMMUNE GLOBULIN (CUTAQUIG), 100 MG | Healthcare Administered Drugs | Y | | | |
| J1552 | INJ, IMMUNE GLOBULIN (ALYGLO), 100 MG | Healthcare Administered Drugs | Y | | | |
| J1554 | INJECTION, IMMUNE GLOBULIN (ASCENIV), 500 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | |
| J1555 | INJECTION, IMMUNE GLOBULIN (CUVITRU), 100 MG | Healthcare Administered Drugs | Y | | | |
| J1556 | INJECTION IMMUNE GLOBULIN BIVIGAM 500 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | |
| J1557 | INJ IMMUNE GLOBULIN IV NONLYOPHILIZED 500 MG (GAMMAPLEX) | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | |
| J1558 | INJECTION, IMMUNE GLOBULIN (XEMBIFY), 100 MG | Healthcare Administered Drugs | Y | | | |
| J1559 | INJECTION IMMUNE GLOBULIN HIZENTRA 100 MG | Healthcare Administered Drugs | Y | | | |
| J1560 | INJECTION GAMMA GLOB INTRAMUSCULAR OVER 10 CC | Healthcare Administered Drugs | Y | | | |
| J1561 | INJECTION IMMUNE GLOBULIN NONLYOPHILIZED 500 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | |

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| J1566 | INJ IG IV LYPHILIZED NOT OTHERWISE SPEC 500 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | |
| J1568 | INJ IG OCTOGAM IV NONLYOPHILIZED 500 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | |
| J1569 | INJ IG GAMMAGARD LIQ IV NONLYOPHILIZED 500 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | |
| J1572 | INJ IMMUNE GLOBULIN IV NONLYOPHILIZED 500 MG (FLEBOGAMMA/FLEBOGAMMA DIF) | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | |
| J1573 | INJ HEP B IG HEPAGAM B INTRAVENOUS 0.5 ML | Healthcare Administered Drugs | Y | | | |
| J1575 | INJ IMMUNE GLOBULIN HYALURONIDASE 100 MG IG | Healthcare Administered Drugs | Y | | | |
| J1576 | INJECTION, IMMUNE GLOBULIN (PANZYGA), INTRAVENOUS, NONLYOPHILIZED (E.G., LIQUID), 500 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | |
| J1595 | INJECTION GLATIRAMER ACETATE 20 MG | Healthcare Administered Drugs | Y | | | |
| J1599 | INJ IG IV NONLYOPHILIZED E.G. LIQUID NOS 500 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | |
| J1602 | INJECTION GOLIMUMAB 1 MG FOR INTRAVENOUS USE | Healthcare Administered Drugs | Y | | | |
| J1627 | INJECTION GRANISETRON EXTENDED-RELEASE 0.1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J1628 | INJECTION GUSELKUMAB 1 MG | Healthcare Administered Drugs | Y | | | |
| J1632 | INJECTION, BREXANOLONE, 1 MG | Healthcare Administered Drugs | Y | | | |
| J1640 | INJECTION HEMIN 1 MG | Healthcare Administered Drugs | Y | | | |
| J1645 | INJECTION DALTEPARIN SODIUM PER 2500 IU | Healthcare Administered Drugs | Y | | | |
| J1729 | INJECTION HYDROXYPROGESTERONE CAPROATE NOS 10 MG | Healthcare Administered Drugs | Y | | | |
| J1740 | INJECTION IBANDRONATE SODIUM 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J1743 | INJECTION IDURSULFASE 1 MG | Healthcare Administered Drugs | Y | | | |
| J1744 | INJECTION ICATIBANT 1 MG | Healthcare Administered Drugs | Y | | | |
| J1745 | INJECTION INFLIXIMAB EXCLUDES BIOSIMILAR 10 MG | Healthcare Administered Drugs | Y | | | |
| J1746 | INJECTION IBALIZUMAB-UIYK 10 MG | Healthcare Administered Drugs | Y | | | |
| J1747 | INJECTION, SPESOLIMAB-SBZO, 1 M | Healthcare Administered Drugs | Y | | | |
| J1748 | INJ, INFLIXIMAB-DYYB (ZYMFENTRA), 10 MG | Healthcare Administered Drugs | Y | | | |
| J1786 | INJECTION IMIGLUCERASE 10 UNITS | Healthcare Administered Drugs | Y | | | |
| J1809 | INJ, FOSDENOPTERIN, 0.1 MG | Healthcare Administered Drugs | Y | | | |
| J1823 | INJECTION, INEBILIZUMAB-CDON, 1 MG | Healthcare Administered Drugs | Y | | | |

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|---|---|---|---|---|---|---|
| J1826 | INJECTION INTERFERON BETA-1A 30 MCG | Healthcare Administered Drugs | Y | | | |
| J1830 | INJECTION INTERFERON BETA-1B 0.25 MG | Healthcare Administered Drugs | Y | | | |
| J1833 | INJECTION ISAVUCONAZONIUM 1 MG | Healthcare Administered Drugs | Y | | | |
| J1930 | INJECTION LANREOTIDE 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J1931 | INJECTION LARONIDASE 0.1 MG | Healthcare Administered Drugs | Y | | | |
| J1932 | INJ LANREOTIDE CIPLA 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J1941 | INJECTION, FUROSEMIDE (FUROSCIX), 20 MG | Healthcare Administered Drugs | Y | | | |
| J1950 | INJECTION LEUPROLIDE ACETATE PER 3.75 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J1951 | INJECTION LEUPROLIDE AC FOR DEPOT SUSP 0.25 MG | Healthcare Administered Drugs | Y | | | |
| J1952 | LEUPROLIDE INJECTABLE, CAMCEVI, 1MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J1954 | INJ LUTRATE DEPOT 7.5 MG (CIPLA) | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J1961 | INJECTION, LENACAPAVIR, 1 MG | Healthcare Administered Drugs | Y | | | |
| J2170 | INJECTION MECASERMIN 1 MG | Healthcare Administered Drugs | Y | | | |
| J2182 | INJECTION MEPOLIZUMAB 1 MG | Healthcare Administered Drugs | Y | | | |
| J2186 | INJECTION MEROPENEM VABORBACTAM 10 MG 10 MG | Healthcare Administered Drugs | Y | | | |
| J2267 | INJ, MIRIKIZUMAB-MRKZ, 1 MG | Healthcare Administered Drugs | Y | | | |
| J2277 | INJECTION, MOTIXAFORTIDE, 0.25 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | |
| J2323 | INJECTION NATALIZUMAB 1 MG | Healthcare Administered Drugs | Y | | | |
| J2326 | INJECTION NUSINERSEN 0.1 MG | Healthcare Administered Drugs | Y | | | |
| J2327 | INJ RISANKIZUMAB-RZAA 1 MG | Healthcare Administered Drugs | Y | | | |
| J2329 | INJECTION, UBLITUXIMAB-XIIY, 1MG | Healthcare Administered Drugs | Y | | | |
| J2350 | INJECTION OCRELIZUMAB 1 MG | Healthcare Administered Drugs | Y | | | |
| J2351 | INJ, OCRELIZUMAB, 1 MG AND HYALURONIDASE-OCSQ | Healthcare Administered Drugs | Y | | | |
| J2353 | INJ OCTREOTIDE DEPOT FORM IM INJ 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J2354 | INJ OCTREOTIDE NON-DEPOT FORM SUBQ/IV INJ 25 MCG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J2356 | INJECTION, TEZEPELUMB-EKKO, 1 MG | Healthcare Administered Drugs | Y | | | |

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| J2357 | INJECTION OMALIZUMAB 5 MG | Healthcare Administered Drugs | Y | | | |
| J2406 | INJECTION, ORITAVANCIN (KIMYRSA), 10 MG | Healthcare Administered Drugs | Y | | | |
| J2407 | INJECTION, ORITAVANCIN (ORBACTIV), 10 MG | Healthcare Administered Drugs | Y | | | |
| J2425 | INJECTION PALIFERMIN 50 MICROGRAMS | Healthcare Administered Drugs | Y | | | |
| J2502 | INJECTION PASIREOTIDE LONG ACTING 1 MG | Healthcare Administered Drugs | Y | | | |
| J2506 | INJECTION, PEGFILGRASTIM, EXCLUDES BIOSIMILAR, 0.5 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J2507 | INJECTION PEGLOTICASE 1 MG | Healthcare Administered Drugs | Y | | | |
| J2508 | INJ, PEGUNIGALSIDASE ALFA-IWXJ, 1 MG | Healthcare Administered Drugs | Y | | | |
| J2562 | INJECTION PLERIXAFOR 1 MG | Healthcare Administered Drugs | Y | | | |
| J2724 | INJECTION PROTEN C CONCENTRATE IV HUMAN 10 IU | Healthcare Administered Drugs | Y | | | |
| J2777 | INJ FARICIMAB-SVOA 0.1 MG | Healthcare Administered Drugs | Y | | | |
| J2778 | INJECTION RANIBIZUMAB 0.1 MG | Healthcare Administered Drugs | Y | | | |
| J2779 | INJECTION, RANIBIZUMAB, VIA INTRAVITREAK IMPLANT (SUSVIMO), 0.1 MG | Healthcare Administered Drugs | Y | | | |
| J2781 | INJECTION, PEGCETACOPLAN, INTRAVITREAL, 1 MG | Healthcare Administered Drugs | Y | | | |
| J2782 | INJECTION, AVACINCAPTED PEGOL, 0.1 MG | Healthcare Administered Drugs | Y | | | |
| J2783 | INJECTION RASBURICASE 0.5 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J2786 | INJECTION RESLIZUMAB 1 MG | Healthcare Administered Drugs | Y | | | |
| J2787 | RIBOFLAVIN 5'-PHOSPHATE OPHTHALMIC SOL TO 3 ML | Healthcare Administered Drugs | Y | | | |
| J2793 | INJECTION RILONACEPT 1 MG | Healthcare Administered Drugs | Y | | | |
| J2802 | INJ, ROMIPLOSTIM, 1 MICROGRAM | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J2820 | INJECTION SARGRAMOSTIM 50 MCG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J2840 | INJECTION SEBELIPASE ALFA 1 MG | Healthcare Administered Drugs | Y | | | |
| J2860 | INJECTION SILTUXIMAB 10 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | |
| J2941 | INJECTION SOMATROPIN 1 MG | Healthcare Administered Drugs | Y | | | |
| J2998 | INJECTION, PLASMINOGEN, HUMAN-TVMH, 1 MG | Healthcare Administered Drugs | Y | | | |
| J3031 | INJECTION FREMANEZUMAB-VFRM 1 MG | Healthcare Administered Drugs | Y | | | |
| J3032 | INJECTION, EPTINEZUMAG-JJMR, 1MG | Healthcare Administered Drugs | Y | | | |
| J3055 | INJECTION, TALQUETAMAB-TGVS, 0.25 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J3060 | INJECTION TALIGLUCERASE ALFA 10 UNITS | Healthcare Administered Drugs | Y | | | |
| J3090 | INJECTION TEDIZOLID PHOSPHATE 1 MG | Healthcare Administered Drugs | Y | | | |
| J3095 | INJECTION TELAVANCIN 10 MG | Healthcare Administered Drugs | Y | | | |

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|---|---|---|---|---|---|---|
| J3110 | INJECTION TERIPARATIDE 10 MCG | Healthcare Administered Drugs | Y | | | |
| J3111 | INJECTION, ROMOSOZUMAB-AQQG, 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | |
| J3145 | INJECTION TESTOSTERONE UNDECANOATE 1 MG | Healthcare Administered Drugs | Y | | | |
| J3241 | INJECTION, TEPROTUMUMAB-TRBW, 10MG | Healthcare Administered Drugs | Y | | | |
| J3245 | INJECTION TILDRAKIZUMAB 1 MG | Healthcare Administered Drugs | Y | | | |
| J3247 | INJ, SECUKINUMAB, INTRAVENOUS, 1 MG | Healthcare Administered Drugs | Y | | | |
| J3262 | INJECTION TOCILIZUMAB 1 MG | Healthcare Administered Drugs | Y | | | |
| J3263 | INJ, TORIPALIMAB-TPZI, 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J3285 | INJECTION TREPROSTINIL 1 MG | Healthcare Administered Drugs | Y | | | |
| J3299 | INJECTION TRIAMCINOLONE ACETONIDE XIPERE 1 MG | Healthcare Administered Drugs | Y | | | |
| J3304 | INJECT TRIAMCINOLONE ACETONIDE PF ER MS F 1 MG | Healthcare Administered Drugs | Y | | | |
| J3315 | INJECTION TRIPTORELIN PAMOATE 3.75 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J3316 | INJECTION TRIPTORELIN EXTENDED-RELEASE 3.75 MG | Healthcare Administered Drugs | Y | | | |
| J3357 | USTEKINUMAB FOR SUBCUTANEOUS INJECTION 1 MG | Healthcare Administered Drugs | Y | | | |
| J3358 | USTEKINUMAB FOR INTRAVENOUS INJECTION 1 MG | Healthcare Administered Drugs | Y | | | |
| J3380 | INJECTION VEDOLIZUMAB 1 MG | Healthcare Administered Drugs | Y | | | |
| J3385 | INJECTION VELAGLUCERASE ALFA 100 UNITS | Healthcare Administered Drugs | Y | | | |
| J3396 | INJECTION VERTEPORFIN 0.1 MG | Healthcare Administered Drugs | Y | | | |
| J3397 | INJECTION VESTRONIDASE ALFA-VJBK 1 MG | Healthcare Administered Drugs | Y | | | |
| J3490 | UNCLASSIFIED DRUGS | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Inpatient, Pediatrics, or drug not listed in Evolent Scope direct request to the healthplan. For Adults ≥ 18 with cancer diagnosis for drugs listed in Evolent scope, direct request to Evolent. | |
| J3590 | UNCLASSIFIED BIOLOGICS | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Inpatient, Pediatrics, or drug not listed in Evolent Scope direct request to the healthplan. For Adults ≥ 18 with cancer diagnosis for drugs listed in Evolent scope, direct request to Evolent. | Y |
| J3591 | UNCLASS RX BIOLOGICAL USED FOR ESRD ON DIALYSIS | Healthcare Administered Drugs | Y | | | |
| J7168 | PRT COMPLEX CONC KCENTRA PER IU FIX ACT | Healthcare Administered Drugs | Y | | | |
| J7170 | INJECTION EMICIZUMAB-KXWH 0.5 MG | Healthcare Administered Drugs | Y | | | |
| J7171 | INJ, ADAMTS13, RECOMBINANT-KRHN, 10 IU | Healthcare Administered Drugs | Y | | | |
| J7172 | INJ MARSTACIMAB, 0.5 MG | Healthcare Administered Drugs | Y | | | |
| J7173 | INJ, CONCIZUMAB-MTCI, 0.5 MG | Healthcare Administered Drugs | Y | | | |
| J7174 | INJ, FITUSIRAN, 0.04 MG | Healthcare Administered Drugs | Y | | | |
| J7175 | INJECTION FACTOR X 1 I.U. | Healthcare Administered Drugs | Y | | | |
| J7177 | INJECTION HUMAN FIBRINOGEN CONCENTRATE 1 MG | Healthcare Administered Drugs | Y | | | |
| J7178 | INJECTION HUMAN FIBRINOGEN CONC NOS 1 MG | Healthcare Administered Drugs | Y | | | |
| J7179 | INJECTION VON WILLEBRAND FACTOR 1 I.U. VWF:RCO | Healthcare Administered Drugs | Y | | | |
| J7180 | INJECTION FACTOR XIII 1 I.U. | Healthcare Administered Drugs | Y | | | |

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|---|---|---|---|---|---|---|
| J7181 | INJECTION FACTOR XIII A-SUBUNIT PER IU | Healthcare Administered Drugs | Y | | | |
| J7182 | INJECTION FACTOR VIII PER IU (ANTIHEMOPHILIC FACTOR, RECOMBINANT), (NOVOEIGHT) | Healthcare Administered Drugs | Y | | | |
| J7183 | INJ VON WILLEBRAND FACTR COMPLEX WILATE 1 IU:RCO | Healthcare Administered Drugs | Y | | | |
| J7185 | INJECTION FACTOR VIII PER IU (ANTIHEMOPHILIC FACTOR, RECOMBINANT) (XYNTHA) | Healthcare Administered Drugs | Y | | | |
| J7186 | INJ AHF VWF CMPLX PER FACTOR VIII IU | Healthcare Administered Drugs | Y | | | |
| J7187 | INJ VONWILLEBRND FACTOR CMPLX HUMN RISTOCETIN IU | Healthcare Administered Drugs | Y | | | |
| J7188 | INJECTION FACTOR VIII PER I.U. | Healthcare Administered Drugs | Y | | | |
| J7189 | FACTOR VIIA ANTIHEMOPHILIC FCT NOVOSEVEN RT1 MCG | Healthcare Administered Drugs | Y | | | |
| J7190 | FACTOR VIII ANTIHEMOPHILIC FACTOR HUMAN PER IU | Healthcare Administered Drugs | Y | | | |
| J7191 | FACTOR VIII ANTIHEMOPHILIC FACTOR PROCINE PER IU | Healthcare Administered Drugs | Y | | | |
| J7192 | FACTOR VIII PER IU NOT OTHERWISE SPECIFIED | Healthcare Administered Drugs | Y | | | |
| J7193 | FACTOR IX AHF PURIFIED NON-RECOMBINANT PER IU | Healthcare Administered Drugs | Y | | | |
| J7194 | FACTOR IX COMPLEX PER IU | Healthcare Administered Drugs | Y | | | |
| J7195 | INJ FACTOR IX PER IU NOT OTHERWISE SPECIFIED | Healthcare Administered Drugs | Y | | | |
| J7196 | INJECTION ANTITHROMBIN RECOMBINANT 50 I.U. | Healthcare Administered Drugs | Y | | | |
| J7197 | ANTITHROMBIN III PER IU | Healthcare Administered Drugs | Y | | | |
| J7198 | ANTI-INHIBITOR PER IU | Healthcare Administered Drugs | Y | | | |
| J7199 | HEMOPHILIA CLOTTING FACTOR NOC | Healthcare Administered Drugs | Y | | | |
| J7200 | INJECTION FACTOR IX RIXUBIS PER IU | Healthcare Administered Drugs | Y | | | |
| J7201 | INJECTION FAC IX FC FUS PROTEIN ALPROLIX 1 I.U. | Healthcare Administered Drugs | Y | | | |
| J7202 | INJECTION FAC IX ALBUMIN FUS PRT IDELVION 1 I.U. | Healthcare Administered Drugs | Y | | | |
| J7203 | INJECTION FACTOR IX GLYCOPEGYLATED 1 IU | Healthcare Administered Drugs | Y | | | |
| J7204 | INJ FACTR VIII ANTIHEM FAC GLYCOPEGYLATD-EXEI P-IU | Healthcare Administered Drugs | Y | | | |
| J7205 | INJECTION FACTOR VIII FC FUSION PROTEIN PER IU | Healthcare Administered Drugs | Y | | | |
| J7207 | INJECTION FACTOR VIII PEGYLATED 1 I.U. | Healthcare Administered Drugs | Y | | | |
| J7208 | INJECTION FACTOR VIII PEGYLATED-AUCL 1 IU | Healthcare Administered Drugs | Y | | | |
| J7209 | INJECTION FACTOR VIII 1 I.U. | Healthcare Administered Drugs | Y | | | |
| J7210 | INJECTION FACTOR VIII AFSTYLA 1 I.U. | Healthcare Administered Drugs | Y | | | |
| J7211 | INJECTION FACTOR VIII KOVALTRY 1 I.U. | Healthcare Administered Drugs | Y | | | |
| J7212 | FCTR VIIA (ANTIHEMOPHILIC F FACTOR, RECOMBINANT)- JNCW (SEVENFACT), 1 MCG | Healthcare Administered Drugs | Y | | | |
| J7213 | INJECTION, COAGULATION FACTOR IX (RECOMBINANT), IXINITY, 1 I.U. | Healthcare Administered Drugs | Y | | | |
| J7214 | INJECTION, FACTOR VIII/VON WILLEBRAND FACTOR COMPLEX, RECOMBINANT (ALTUVIIIO), PER FACTOR VIII I.U.” | Healthcare Administered Drugs | Y | | | |
| J7308 | AMINOLEVULINIC ACID HCL TOP ADMN 20PCT 1 U DOSE | Healthcare Administered Drugs | Y | | | |
| J7311 | FLUOCINOLONE ACETONIDE INTRAVITREAL IMPLANT | Healthcare Administered Drugs | Y | | | |
| J7312 | INJECTION DEXAMETHASONE INTRAVITREAL IMPL 0.1 MG | Healthcare Administered Drugs | Y | | | |
| J7313 | INJECTION FA INTRAVITREAL IMPLANT (LLUVIEN) 0.01 MG | Healthcare Administered Drugs | Y | | | |
| J7314 | INJECTION FA INTRAVITREAL IMPLANT (YUTIQ), 0.01 MG | Healthcare Administered Drugs | Y | | | |
| J7318 | HYALURONAN DERIVATIVE DUROLANE FOR IA INJ 1 MG | Healthcare Administered Drugs | Y | | | |
| J7320 | HYALURONAN DERIVITIVE GENVISC 850 IA INJ 1 MG | Healthcare Administered Drugs | Y | | | |
| J7321 | HYALURONAN/DERIV HYALGAN/SUPARTZ IA INJ PER DOSE | Healthcare Administered Drugs | Y | | | |
| J7322 | HYALURONAN DERIVATIVE HYMOVIS IA INJ 1 MG | Healthcare Administered Drugs | Y | | | |
| J7323 | HYALURONAN DERIVATIVE EUFLEXXA IA INJ PER DOSE | Healthcare Administered Drugs | Y | | | |
| J7324 | HYALURONAN DERIV ORTHOVISC IA INJ PER DOSE | Healthcare Administered Drugs | Y | | | |
| J7325 | HYALURONAN DERIV SYNVISC SYNVISC-ONE IA INJ 1 MG | Healthcare Administered Drugs | Y | | | |
| J7326 | HYALURONAN DERIV GEL-ONE INTRA-ARTIC INJ PER DOS | Healthcare Administered Drugs | Y | | | |

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| J7327 | HYALURONAN DERIVATIVE MONOVISC IA INJ PER DOSE | Healthcare Administered Drugs | Y | | | |
| J7328 | HYALURONAN DERIVATIVE GELSYN-3 FOR IA INJ 0.1 MG | Healthcare Administered Drugs | Y | | | |
| J7329 | HYALURONAN DERIVATIVE TRIVISC FOR IA INJ 1 MG | Healthcare Administered Drugs | Y | | | |
| J7331 | HYALURONAN/DERIVATIVE SYNOJOYNT IA INJ 1 MG | Healthcare Administered Drugs | Y | | | |
| J7332 | HYALURONAN/DERIVATIVE TRILURON IA INJ 1 MG | Healthcare Administered Drugs | Y | | | |
| J7336 | CAPSAICIN 8% PATCH, PER SQ CENTIMETER | Healthcare Administered Drugs | Y | | | |
| J7351 | INJECTION BIMATOPROST INTRACAMERAL IMPLANT 1 MCG | Healthcare Administered Drugs | Y | | | |
| J7352 | AFAMELANOTIDE IMPLANT, 1 MG | Healthcare Administered Drugs | Y | | | |
| J7353 | ANACAULASE-BCDB, 8.8% GEL, 1 GRAM | Healthcare Administered Drugs | Y | | | |
| J7354 | CANTHARIDIN FOR TOPICAL ADMINISTRATION, 0.7%, SINGLE UNIT DOSE APPLICATOR (3.2 MG) | Healthcare Administered Drugs | Y | | | |
| J7355 | INJ, TRAVOPROST, INTRACAMERAL IMPLANT, 1 MICROGRAM | Healthcare Administered Drugs | Y | | | |
| J7356 | INJ, FOSCARBIDOPA 0.25 MG/FOSLEVODOPA 5 MG | Healthcare Administered Drugs | Y | | | |
| J7402 | MOMETASONE FUROATE SINUS IMPLANT SINUVA 10 MCG | Healthcare Administered Drugs | Y | | | |
| J7504 | LYMPHCYT IMMUN GLOB EQUINE PARENTERAL 250 MG | Healthcare Administered Drugs | Y | | | |
| J7511 | LYMPHCYT IMMUN GLOB RABBIT PARENTERAL 25 MG | Healthcare Administered Drugs | Y | | | |
| J7601 | ENSIFENTRINE, INHALATION SUSPENSION, FDA APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 3 MG | Healthcare Administered Drugs | Y | | | |
| J7639 | DORNASE ALFA INHAL SOL NONCOMP UNIT DOSE PER MG | Healthcare Administered Drugs | Y | | | |
| J7677 | REVEFENACIN INHAL SOL NONCOMPND ADM DME 1 MCG | Healthcare Administered Drugs | Y | | | |
| J7682 | TOBRAMYCIN INHAL NON-COMP UNIT DOSE PER 300 MG | Healthcare Administered Drugs | Y | | | |
| J7686 | TREPROSTINIL INHAL SOLUTION UNIT DOSE 1.74 MG | Healthcare Administered Drugs | Y | | | |
| J7999 | COMPOUNDED DRUG NOT OTHERWISE CLASSIFIED | Healthcare Administered Drugs | Y | | Bevacizumab when billed for intraocular injection does not require a PA | |
| J8499 | PRESCRIPTION DRUG ORAL NONCHEMOTHERAPEUTIC NOS | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Inpatient, Pediatrics, or drug not listed in Evolent Scope direct request to the healthplan. For Adults ≥ 18 with cancer diagnosis for drugs listed in Evolent scope, direct request to Evolent. | |
| J8655 | NETUPITANT 300 MG AND PALONOSETRON 0.5 MG ORAL | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | |
| J8670 | ROLAPITANT ORAL 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | |
| J8999 | PRESCRIPTION DRUG ORAL CHEMOTHERAPEUTIC NOS | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Inpatient, Pediatrics, or drug not listed in Evolent Scope direct request to the healthplan. For Adults ≥ 18 with cancer diagnosis for drugs listed in Evolent scope, direct request to Evolent. | |
| J9000 | INJECTION DOXORUBICIN HCL 10 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9011 | INJ, DATOPOTAMAB DERUXTECANDLNK, 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |

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| J9015 | INJECTION ALDESLEUKIN PER SINGLE USE VIAL | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9017 | INJECTION ARSENIC TRIOXIDE 1 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9019 | INJECTION ASPARAGINASE ERWINAZE 1000 IU | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | |
| J9021 | INJECTION, ASPARAGINASE, RECOMBINANT, (RYLAZE), 0.1MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9022 | INJECTION ATEZOLIZUMAB 10 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9023 | INJECTION AVELUMAB 10 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9024 | INJ, ATEZOLIZUMAB, 5 MG AND HYALURONIDASE-TQJS | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9025 | INJECTION AZACITIDINE 1 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9026 | INJ, TARLATAMAB-DLLE, 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9027 | INJECTION CLOFARABINE 1 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9028 | INJ, NOGAPENDEKIN ALFA INBAKICEPT-PMLN, FOR INTRAVESICAL USE, 1 MICROGRAM | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9030 | BCG LIVE INTRAVESICAL INSTILLATION 1 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |

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| J9032 | INJECTION BELINOSTAT 10 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9033 | INJECTION BENDAMUSTINE HCL TREANDA 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9034 | INJECTION BENDAMUSTINE HCL BENDEKA 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9035 | INJECTION BEVACIZUMAB 10 MG | Healthcare Administered Drugs | Y | Y~ | Bevacizumab when billed for intraocular injection does not require a PA. ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9036 | INJECTION BENDAMUSTINE HYDROCHLORIDE 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9038 | INJ, AXATILIMAB-CSFR, 0.1 MG | Healthcare Administered Drugs | Y | | | |
| J9039 | INJECTION BLINATUMOMAB 1 MICROGRAM | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9040 | INJECTION BLEOMYCIN SULFATE 15 UNITS | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9041 | INJECTION BORTEZOMIB 0.1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9042 | INJECTION BRENTUXIMAB VEDOTIN 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9043 | INJECTION CABAZITAXEL 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9045 | INJECTION CARBOPLATIN 50 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9046 | INJ, BORTEZOMIB, DR. REDDY'S | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |

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| J9047 | INJECTION CARFILZOMIB 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9048 | INJ, BORTEZOMIB FRESENIUSKAB | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9049 | INJ, BORTEZOMIB, HOSPIRA | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9050 | INJECTION CARMUSTINE 100 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9051 | INJECTION, BORTEZOMIB (MAIA), NOT THERAPEUTICALLY EQUIVALENT TO J9041, 0.1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9052 | INJ, CARMUSTINE (ACCORD) | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9054 | INJ, BORTEZOMIB (BORUZU), 0.1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9055 | INJECTION CETUXIMAB 10 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9056 | INJECTION, BENDAMUSTINE HYDROCHLORIDE (VIVIMUSTA), 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9057 | INJECTION COPANLISIB 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | |
| J9060 | INJECTION CISPLATIN POWDER OR SOLUTION 10 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9061 | INJECTION, AMIVANTAMAB-VMJW, 2MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |

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| J9063 | INJECTION, MIRVETUXIMAB SORAVTANSINE-GYNX, 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9064 | INJECTION, CABAZITAXEL (SANDOZ), NOT THERAPEUTICALLY EQUIVALENT TO J9043, 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9065 | INJECTION CLADRIBINE PER 1 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9071 | INJECTION CYCLOPHOSPHAMIDE AUROMEDICS 5 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9072 | INJ, CYCLOPHOSPHAMIDE, (DR. REDDY'S), 5 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9073 | INJECTION, CYCLOPHOSPHAMIDE (INGENUS), 5 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9074 | INJECTION, CYCLOPHOSPHAMIDE (SANDOZ), 5 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9075 | INJECTION, CYCLOPHOSPHAMIDE, NOT OTHERWISE SPECIFIED, 5MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9076 | INJ, CYCLOPHOSPHAMIDE (BAXTER) 5MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9100 | INJECTION CYTARABINE 100 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9118 | INJ. CALASPARGASE PEGOL-MKNL | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9119 | INJECTION CEMIPLIMAB-RWLC 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |

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| J9120 | INJECTION DACTINOMYCIN 0.5 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9130 | DACARBAZINE 100 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9144 | INJECTION, DARATUMUMAB, 10 MG AND HYALURONIDASE-FIHJ | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9145 | INJECTION DARATUMUMAB 10 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9150 | INJECTION DAUNORUBICIN 10 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9153 | INJECTION LIPOSOMAL 1 MG DNR AND 2.27 MG CA | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9155 | INJECTION DEGARELIX 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9161 | INJ, DENILEUKIN DIFTITOX-CXDL, 1 MCG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9171 | INJECTION DOCETAXEL 1 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9172 | DOCETAXEL (INGENUS), 1 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9173 | INJECTION DURVALUMAB 10 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9174 | INJ, DOCETAXEL (BEIZRAY), 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |

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| J9176 | INJECTION ELOTUZUMAB 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9177 | INJECTION, ENFORTUMAB VEDOTIN-EJFV, 0.25 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9178 | INJECTION EPIRUBICIN HCL 2 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9179 | INJECTION ERIBULIN MESYLATE 0.1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9181 | INJECTION ETOPOSIDE 10 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9185 | INJECTION FLUDARABINE PHOSPHATE 50 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9190 | INJECTION FLUOROURACIL 500 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9196 | INJECTION, GEMCITABINE HYDROCHLORIDE (ACCORD), NOT THERAPEUTICALLY EQUIVALENT TO J9201, 200 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9198 | INJECTION, GEMCITABINE HYDROCHLORIDE (INFUGEM), 100 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9200 | INJECTION FLOXURIDINE 500 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9201 | INJECTION GEMCITABINE HCL NOS 200 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9202 | GOSERELIN ACETATE IMPLANT PER 3.6 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |

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| J9203 | INJECTION GEMTUZUMAB OZOGAMICIN 0.1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9204 | INJECTION MOGAMULIZUMAB-KPKC 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9205 | INJECTION IRINOTECAN LIPOSOME 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9206 | INJECTION IRINOTECAN 20 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9207 | INJECTION IXABEPILONE 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9208 | INJECTION IFOSFAMIDE 1 G | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9209 | INJECTION MESNA 200 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9210 | INJECTION EMAPALUMAB-LZSG 1 MG | Healthcare Administered Drugs | Y | | | |
| J9211 | INJECTION IDARUBICIN HCL 5 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9214 | INJECTION INTERFERON ALFA-2B RECOMBINANT 1 M U | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9215 | INJECTION INTERFERON ALFA-N3 250,000 IU | Healthcare Administered Drugs | Y | | | |
| J9216 | INJECTION INTERFERON GAMMA-1B 3 MILLION UNITS | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9217 | LEUPROLIDE ACETATE 7.5 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |

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| J9218 | LEUPROLIDE ACETATE PER 1 MG | Healthcare Administered Drugs | Y | Y~ | One J code unit allowed per calendar year. All units in excess of one unit/year requires PA.<br>~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults > 18 with cancer diagnosis, direct request to Evolent. For Inpatient, Pediatrics, and Non Cancer Diagnosis direct request to the healthplan. | Y |
| J9223 | INJECTION, LURBINECTEDIN, 0.1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9225 | HISTRELIN IMPLANT VANTAS 50 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | |
| J9226 | HISTRELIN IMPLANT SUPPRELIN LA 50 MG | Healthcare Administered Drugs | Y | | | |
| J9227 | INJECTION, ISATUXIMAB-IRFC, 10 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9228 | INJECTION IPILIMUMAB 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9229 | INJECTION INOTUZUMAB OZOGAMICIN 0.1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9245 | INJECTION MELPHALAN HCI NOS 50 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9246 | INJECTION MELPHALAN EVOMELA 1 MG | Healthcare Administered Drugs | Y | | | |
| J9248 | INJECTION, MELPHALAN (HEPZATO), 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9249 | INJECTION MELPHALAN APOTEX 1 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9255 | INJ, METHOTREXATE (ACCORD) | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9260 | INJECTION METHOTREXATE SODIUM 50 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |

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| J9261 | INJECTION NELARABINE 50 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9262 | INJECTION OMACETAXINE MEPESUCCINATE 0.01 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | |
| J9263 | INJECTION OXALIPLATIN 0.5 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9264 | INJECTION PACLITAXEL PROTEINBOUND PARTICLES 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9266 | INJECTION PEGASPARGASE PER SINGLE DOSE VIAL | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9267 | INJECTION PACLITAXEL 1 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9268 | INJECTION PENTOSTATIN 10 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9269 | INJECTION TAGRAXOFUSP-ERZS 10 MCG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9271 | INJECTION PEMBROLIZUMAB 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9272 | INJECTION, DOSTARLIMAB-GXLY,10MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9273 | INJECTION, TISOTUMAB VEDOTIN-TFTV, 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9274 | INJ TEBENTAFUSP-TEBN 1 MCG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |

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| J9275 | INJ, COSIBELIMAB-IPDL, 2 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9276 | INJ ZANIDATAMAB, 2 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9280 | INJECTION MITOMYCIN 5 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9281 | MITOMYCIN PYELOCALYCEAL INSTILLATION, 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9285 | INJECTION OLARATUMAB 10 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | |
| J9286 | INJ, GLOFITAMAB-GXBM, 2.5 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9289 | INJ, NIVOLUMAB, 2 MG AND HYALURONIDASENVHY | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9292 | INJ, PEMETREXED (AVYXA), NOT THERAPEUTICALLY EQUIVALENT TO J9305, 10 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9293 | INJECTION MITOXANTRONE HCL PER 5 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9294 | INJECTION, PEMETREXED (HOSPIRA) NOT THERAPEUTICALLY EQUIVALENT TO J9305, 10 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9295 | INJECTION NECITUMUMAB 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9296 | INJECTION, PEMETREXED (ACCORD) NOT THERAPEUTICALLY EQUIVALENT TO J9305, 10 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |

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| J9297 | INJECTION, PEMETREXED (SANDOZ), NOT THERAPEUTICALLY EQUIVALENT TO J9305, 10 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9298 | INJ NIVOLUMAB AND RELATLIMAB-RMBW 3 MG/1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9299 | INJECTION NIVOLUMAB 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9301 | INJECTION OBINUTUZUMAB 10 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9302 | INJECTION OFATUMUMAB 10 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | |
| J9303 | INJECTION PANITUMUMAB 10 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9304 | INJECTION PEMETREXED (PEMFEXY) 10 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9305 | INJECTION PEMETREXED 10 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9306 | INJECTION PERTUZUMAB 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9307 | INJECTION PRALATREXATE 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9308 | INJECTION RAMUCIRUMAB 5 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9309 | INJECTION, POLATUZUMAB VEDOTIN-PIIQ, 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |

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| J9311 | INJECTION RITUXIMAB 10 MG AND HYALURONIDASE | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9312 | INJECTION RITUXIMAB 10 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9313 | INJECTION MOXETUMOMAB PASUDOTOX-TDFK 0.01 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | |
| J9314 | INJ PEMETREXED (TEVA) 10MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9316 | INJECTION, PERTUZUMAB, TRASTUZUMAB, AND HYALURONIDASE-ZZXF, PER 10 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9317 | INJECTION, SACITUZUMAB GOVITECAN-HZIY, 2.5 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9318 | INJECTION, ROMIDEPSIN, NONLYOPHILIZED, 0.1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9319 | INJECTION, ROMIDEPSIN, LYOPHILIZED, 0.1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9320 | INJECTION STREPTOZOCIN 1 G | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9321 | INJECTION EPCORITAMAB-BYSP 0.16 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9322 | INJECTION, PEMETREXED (BLUEPOINT) NOT THERAPEUTICALLY EQUIVALENT TO J9305, 10 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9323 | INJECTION, PEMETREXED DITROMETHAMINE, 10 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |

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| J9324 | INJ, PEMETREXED (PEMRYDI RTU), 10 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9325 | INJ TALIMOGENE LAHERPAREPVEC PER 1 M PLAQUE F U | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9328 | INJECTION TEMOZOLOMIDE 1 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9329 | INJ, TISLELIZUMAB-JSGR, 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9330 | INJECTION TEMSIROLIMUS 1 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9331 | INJECTION, SIROLIMUS PROTEIN-BOUND PARTICLES, 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9332 | INJECTION, EFGARTIGIMOD ALFA-FCAB, 2 MG | Healthcare Administered Drugs | Y | | | |
| J9333 | INJ, ROZANOLIXIZUMAB-NOLI, 1 MG | Healthcare Administered Drugs | Y | | | |
| J9334 | INJ, EFGARTIGIMOD ALFA, 2 MG AND HYALURONIDASE-QVFC | Healthcare Administered Drugs | Y | | | |
| J9341 | INJ, THIOTEPA (TEPYLUTE), 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9342 | INJ, THIOTEPA, NOT OTHRWS SPCFD, 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9345 | INJECTION, RETIFANLIMAB-DLWR, 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9347 | INJECTION, TREMELIMUMAB-ACTL, 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9348 | INJECTION NAXITAMAB-GQGK 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |

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| J9349 | INJECTION, TAFASITAMAB-CXIX, 2 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9350 | INJECTION, MOSUNETUZUMAB-AXGB, 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9351 | INJECTION TOPOTECAN 0.1 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9352 | INJECTION TRABECTEDIN 0.1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9353 | INJECTION MARGETUXIMAB-CMKB 5 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9354 | INJ ADO-TRASTUZUMAB EMTANSINE 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9355 | INJECTION TRASTUZUMAB EXCLUDES BIOSIMILAR 10 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9356 | INJECTION TRASTUZUMAB 10 MG AND HYALURONIDASE-OYSK | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9357 | INJECTION VALRUBICIN INTRAVESICAL 200 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9358 | INJECTION, FAM-TRASTUZUMAB DERUXTECAN-NXKI, 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9359 | INJECTION, LONCASTUXIMAB TESIRINE-LPYL, 0.075 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9360 | INJECTION VINBLASTINE SULFATE 1 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |

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| J9361 | INJ, EFBEMALENOGRASTIM ALFA-VUXW, 0.5 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9370 | VINCRISTINE SULFATE 1 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9376 | INJECTION, POZELIMAB-BBFG, 1 MG | Healthcare Administered Drugs | Y | | | |
| J9380 | INJECTION, TECLISTAMAB-CQYV, 0.5 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9381 | INJECTION, TEPLIZUMAB-MZWV, 5 MCG | Healthcare Administered Drugs | Y | | | |
| J9382 | INJ, ZENOCUTUZUMAB-ZBCO, 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9390 | INJECTION VINORELBINE TARTRATE 10 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9393 | INJ, FULVESTRANT (TEVA) | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9394 | INJ, FULVESTRANT (FRESENIUS) | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9395 | INJECTION FULVESTRANT 25 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9400 | INJECTION ZIV-AFLIBERCEPT 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9600 | INJECTION PORFIMER SODIUM 75 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| J9999 | NOT OTHERWISE CLASSIFIED ANTINEOPLASTIC DRUG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Inpatient, Pediatrics, or drug not listed in Evolent Scope direct request to the healthplan. For Adults ≥ 18 with cancer diagnosis for drugs listed in Evolent scope, direct request to Evolent. | Y |

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| Q0138 | INJ FERUMOXYTOL TX IRON DEF ANEMIA 1 MG NON-ESRD | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| Q0139 | INJ FERUMOXYTOL TX IRON DEF ANEMIA 1 MG FOR ESRD | Healthcare Administered Drugs | Y | | | |
| Q0224 | INJ, PEMIVIBART, 4500 MG | Healthcare Administered Drugs | Y | | | |
| Q0235 | INJ, MNCLNL NTBDY PRDCTS W INDCTN FOR PST-XPSR PRPHYLXS OR TRTMNT OF CVD-19, FOR HSPTLZD ADLTS AND/OR PDTRC PTS RCVNG SYSTMC CRTCSTRDS AND RQR SPPLMNTL OXYGN, NN-NVSV OR NVSV MCHNCL VNTLTN, OR XTRCRPRL MMBRN OXYGNTN (ECMO) ONLY, NOC, 1 MG | Healthcare Administered Drugs | Y | | | |
| Q0516 | SUPPLY FEE HIV PREP 30-DAYS | Healthcare Administered Drugs | NC | | HIV pre-exposure prophylaxis that is self-administered is only covered under the pharmacy benefit. See plan drug list for coverage details. | |
| Q0517 | SUPPLY FEE HIV PREP 60-DAYS | Healthcare Administered Drugs | NC | | HIV pre-exposure prophylaxis that is self-administered is only covered under the pharmacy benefit. See plan drug list for coverage details. | |
| Q0518 | SUPPLY FEE HIV PREP 90-DAYS | Healthcare Administered Drugs | NC | | HIV pre-exposure prophylaxis that is self-administered is only covered under the pharmacy benefit. See plan drug list for coverage details. | |
| Q2017 | INJECTION TENIPOSIDE 50 MG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| Q2050 | INJECTION DOXORUBICIN HCL LIPOSOMAL NOS 10 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| Q3027 | INJECTION INTERFERON BETA-1A 1 MCG IM USE | Healthcare Administered Drugs | Y | | | |
| Q3028 | INJECTION INTERFERON BETA-1A 1 MCG SUBQ USE | Healthcare Administered Drugs | Y | | | |
| Q4074 | ILOPROST INHAL SOL THRU DME UNIT DOSE TO 20 MCG | Healthcare Administered Drugs | Y | | | |
| Q5098 | INJ, USTEKINUMAB-SRLF (IMULDOSA), BIOSIMILAR, 1 MG | Healthcare Administered Drugs | Y | | | |
| Q5099 | INJ, USTEKINUMAB-STBA (STEQEYMA), BIOSIMILAR, 1 MG | Healthcare Administered Drugs | Y | | | |
| Q5100 | INJ, USTEKINUMAB-KFCE (YESINTEK), BIOSIMILAR, 1 MG | Healthcare Administered Drugs | Y | | | |
| Q5101 | INJECTION FILGRASTIM BIOSIMILAR 1 MCG | Healthcare Administered Drugs | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| Q5103 | INJECTION INFLIXIMAB-DYYB BIOSIMILAR 10 MG | Healthcare Administered Drugs | Y | | | |
| Q5104 | INJECTION INFLIXIMAB-ABDA BIOSIMILAR 10 MG | Healthcare Administered Drugs | Y | | | |
| Q5106 | INJECTION EPOETIN ALFA-EPBX BIOSIMILAR 1000 U | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| Q5107 | INJECTION BEVACIZUMAB-AWWB BIOSIMILAR 10 MG | Healthcare Administered Drugs | Y | Y~ | Bevacizumab when billed for intraocular injection does not require PA. ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| Q5108 | INJECTION PEGFILGRASTIM-JMDB BIOSIMILAR 0.5 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |

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| Q5109 | INJECTION INFLIXIMAB-QBTX BIOSIMILAR 10 MG | Healthcare Administered Drugs | Y | | | |
| Q5110 | INJECTION FILGRASTIM-AAFI BIOSIMILAR 1 MCG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| Q5111 | INJECTION PEGFILGRASTIM-CBQV BIOSIMILAR 0.5 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| Q5112 | INJECTION TRASTUZUMAB-DTTB BIOSIMILAR 10 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| Q5113 | INJECTION TRASTUZUMAB-PKRB BIOSIMILAR 10 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| Q5114 | INJECTION TRASTUZUMAB-DKST BIOSIMILAR 10 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| Q5115 | INJECTION RITUXIMAB-ABBS BIOSIMILAR 10 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| Q5116 | INJECTION, TRASTUZUMAG-QYYP, BIOSIMILAR, (TRAZIMERA), 10 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| Q5117 | INJECTION, TRASTUZUMAB-ANNS, BIOSIMILAR (KANJINTI), 10 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| Q5118 | INJECTION, BEVACIZUMAB-BVZR, BIOSIMILAR, (ZIRABEV), 10 MG | Healthcare Administered Drugs | Y | Y~ | Bevacizumab when billed for intraocular injection does not require PA. ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| Q5119 | INJECTION, RITUXIMAB-PVVR, BIOSIMILAR, (RUXIENCE), 10 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| Q5120 | INJECTION, PEGFILGRASTIM-BMEZ, BIOSIMILAR, (ZIEXTENZO), 0.5 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| Q5121 | IJNECTION, INFLIXIMAB-AXXQ, BIOSIMILAR, (AVSOLA), 10 MG | Healthcare Administered Drugs | Y | | | |

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| Q5122 | INJECTION, PEGFILGRASTIM-APGF, BIOSIMILAR, (NYVEPRIA), 0.5 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| Q5123 | INJECTION RITUXIMAB-ARRX BIOSIMILAR 10 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| Q5124 | INJECTION RANIBIZUMAB-NUNA BS BYOOVIZ 0.1 MG | Healthcare Administered Drugs | Y | | | |
| Q5125 | INJ FILGRASTIM-AYOW BIOSIMILAR RELEUKO 1 MCG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| Q5126 | BEVACIZUMAB-MALY, BIOSIMILAR | Healthcare Administered Drugs | Y | Y~ | Bevacizumab when billed for intraocular injection does not require PA. ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| Q5127 | INJECTION, PEGFILGRASTIM-FPGK (STIMUFEND), BIOSIMILAR, 0.5 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| Q5128 | INJECTION, RANIBIZUMAB-EQRN (CIMERLI), BIOSIMILAR, 0.1 MG | Healthcare Administered Drugs | Y | | | |
| Q5129 | INJECTION, BEVACIZUMAB-ADCD (VEGZELMA), BIOSIMILAR, 10 MG | Healthcare Administered Drugs | Y | Y~ | Bevacizumab when billed for intraocular injection does not require PA. ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| Q5130 | INJECTION, PEGFILGRASTIM-PBBK (FYLNETRA), BIOSIMILAR, 0.5 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| Q5133 | INJECTION, TOCILIZUMAB-BAVI (TOFIDENCE), BIOSIMILAR, 1 MG | Healthcare Administered Drugs | Y | | | |
| Q5134 | INJECTION, NATALIZUMAB-SZTN (TYRUKO), BIOSIMILAR, 1 MG | Healthcare Administered Drugs | Y | | | |
| Q5135 | INJ, TOCILIZUMAB-AAZG (TYENNE), BIOSIMILAR, 1 MG | Healthcare Administered Drugs | Y | | | |
| Q5136 | INJ, DENOSUMAB-BBDZ (JUBBONTI/WYOST), BIOSIMILAR, 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| Q5137 | INJ, USTEKINUMAB-AUUB (WEZLANA), BIOSIMILAR, SUBCUTANEOUS, 1 MG | Healthcare Administered Drugs | Y | | | |
| Q5138 | INJ, USTEKINUMAB-AUUB (WEZLANA), BIOSIMILAR, INTRAVENOUS, 1 MG | Healthcare Administered Drugs | Y | | | |
| Q5140 | INJ, ADALIMUMAB-FKJP, BIOSIMILAR, 1 MG | Healthcare Administered Drugs | Y | | | |
| Q5141 | INJ, ADALIMUMAB-AATY, BIOSIMILAR, 1 MG | Healthcare Administered Drugs | Y | | | |
| Q5142 | INJ, ADALIMUMAB-RYVK BIOSIMILAR, 1 MG | Healthcare Administered Drugs | Y | | | |
| Q5143 | INJ, ADALIMUMAB-ADBM, BIOSIMILAR, 1 MG | Healthcare Administered Drugs | Y | | | |
| Q5144 | INJ, ADALIMUMAB-AACF (IDACIO), BIOSIMILAR, 1 MG | Healthcare Administered Drugs | Y | | | |
| Q5145 | INJ, ADALIMUMAB-AFZB (ABRILADA), BIOSIMILAR, 1 MG | Healthcare Administered Drugs | Y | | | |

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| Q5146 | INJ, TRASTUZUMAB-STRF (HERCESSI), BIOSIMILAR, 10 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| Q5147 | INJ, AFLIBERCEPT-AYYH (PAVBLU), BIOSIMILAR, 1 MG | Healthcare Administered Drugs | Y | | | |
| Q5148 | INJ, FILGRASTIM-TXID (NYPOZI), BIOSIMILAR, 1 MICROGRAM | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| Q5149 | INJECTION, AFLIBERCEPT-ABZV (ENZEEVU), BIOSIMILAR, 1 MG | Healthcare Administered Drugs | Y | | | |
| Q5150 | INJ, AFLIBERCEPT-MRBB (AHZANTIVE), BIOSIMILAR, 1 MG | Healthcare Administered Drugs | Y | | | |
| Q5151 | INJ, ECULIZUMAB-AAGH (EPYSQLI), BIOSIMILAR, 2 MG | Healthcare Administered Drugs | Y | | | |
| Q5152 | INJ, ECULIZUMAB-AEEB (BKEMV), BIOSIMILAR, 2 MG | Healthcare Administered Drugs | Y | | | |
| Q5153 | INJ, AFLIBERCEPT-YSZY (OPUVIZ), BIOSIMILAR, 1 MG | Healthcare Administered Drugs | Y | | | |
| Q5154 | INJ, OMALIZUMAB-IGEC (OMLYCLO), BIOSIMILAR, 5 MG | Healthcare Administered Drugs | Y | | | |
| Q5155 | INJ, AFLIBERCEPT-JBVF (YESAFILI), BIOSIMILAR, 1 MG | Healthcare Administered Drugs | Y | | | |
| Q5156 | INJ, TOCILIZUMAB-ANOH (AVTOZMA), BIOSIMILAR, 1 MG | Healthcare Administered Drugs | Y | | | |
| Q5157 | INJ, DENOSUMAB-BMWO (STOBOCLO/OSENVELT), BIOSIMILAR, 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | |
| Q5158 | INJ, DENOSUMAB-BNHT (BOMYNTRA/CONEXXENCE), BIOSIMILAR, 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | |
| Q5159 | INJ, DENOSUMAB-DSSB (OSPOMYV/XBRYK), BIOSIMILAR, 1 MG | Healthcare Administered Drugs | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | |
| Q9996 | INJ, USTEKINUMAB-TTWE (PYZCHIVA), SUBCUTANEOUS, 1 MG | Healthcare Administered Drugs | Y | | | |
| Q9997 | INJ, USTEKINUMAB-TTWE (PYZCHIVA), INTRAVENOUS, 1 MG | Healthcare Administered Drugs | Y | | | |
| Q9998 | INJ, USTEKINUMAB-AEKN (SELARSDI), 1 MG | Healthcare Administered Drugs | Y | | | |
| Q9999 | INJ, USTEKINUMAB-AAUZ (OTULFI), BIOSIMILAR, 1 MG | Healthcare Administered Drugs | Y | | | |
| S0013 | ESKETAMINE, NASAL SPRAY, 1 MG | Healthcare Administered Drugs | Y | | | |
| S0122 | INJECTION MENOTROPINS 75 IU | Healthcare Administered Drugs | Y | | | |
| S0126 | INJECTION FOLLITROPIN ALFA 75 IU | Healthcare Administered Drugs | Y | | | |
| S0128 | INJECTION FOLLITROPIN BETA 75 IU | Healthcare Administered Drugs | Y | | | |
| S0132 | INJECTION GANIRELIX ACETATE 250 MCG | Healthcare Administered Drugs | Y | | | |
| S0145 | INJ PEGYLATED INTERFERON ALFA2A 180 MCG PER ML | Healthcare Administered Drugs | Y | | | |
| S0148 | INJECTION PEGYLATED INTERFERON ALFA-2B 10 MCG | Healthcare Administered Drugs | Y | | | |
| S0157 | BECAPLERMIN GEL 0.01PCT 0.5 GM | Healthcare Administered Drugs | Y | | | |
| S0189 | TESTOSTERONE PELLET 75 MG | Healthcare Administered Drugs | Y | | | |
| S1091 | STENT NONCORONARY TEMPORARY WITH DELIVERY SYSTEM | Healthcare Administered Drugs | Y | | | |
| G0151 | SRVCS PRFRMD BY PHYSCN THRPY HH OR HSPCE EA 15 MIN | Home Health Care Services | Y | | | |
| G0152 | SRVCS PRFRMD BY OCCPNL THRPST HH OR HOSPICE EA 15 MIN | Home Health Care Services | Y | | | |
| G0153 | SRVCS SPCH&LNGGE PTHLGST HH OR HSPCE EA 15 MIN | Home Health Care Services | Y | | | |
| G0155 | SRVC CLINICAL SOCIAL WORKER HH HOSPICE EA 15 MIN | Home Health Care Services | Y | | | |
| G0156 | SRVC HH/HOSPICE AIDE IN HH/HOSPICE SET EA 15 MIN | Home Health Care Services | Y | | | |
| G0157 | SERVICES BY PT ASSIST HOME HEALTH HOSPICE EA 15 MIN | Home Health Care Services | Y | | | |
| G0158 | SERVICE OT ASSISTNT HOME HEALTH HOSPICE EA 15 MIN | Home Health Care Services | Y | | | |

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|---|---|---|---|---|---|---|
| G0159 | SERVICES PT HOME HEALTH EST DEL PT MP EA 15 MINS | Home Health Care Services | Y | | | |
| G0160 | SERVICES OT HOME HEALTH EST DEL OT MP EA 15 MINS | Home Health Care Services | Y | | | |
| G0162 | SKILLED SVCE BY RN E&M PLAN OF CARE; EA 15 MINS | Home Health Care Services | Y | | | |
| G0299 | DIRECT SNS RN HOME HEALTH/HOSPICE SET EA 15 MIN | Home Health Care Services | Y | | | |
| G0300 | DIRECT SNS LPN HOME HLTH HOSPICE SET EA 15 MIN | Home Health Care Services | Y | | | |
| G0490 | FACE-TO-FACE HH NSG VST RHC FQHC AREA SHTG HHA | Home Health Care Services | Y | | | |
| G0493 | SKILLED SERVICES RN OBV AND ASMNT PT CONDTN EA 15 MIN | Home Health Care Services | Y | | | |
| G0494 | SKILLED SRVC LPN OBS AND ASMT PT COND EA 15 MIN | Home Health Care Services | Y | | | |
| G0495 | SKD SRVC RN TRAIN AND EDU PT FAM HH HOSPC EA 15 MIN | Home Health Care Services | Y | | | |
| G0496 | SKD SRVC LPN TRAIN AND EDU PT FAM HH HOSPC E 15 MIN | Home Health Care Services | Y | | | |
| S5150 | UNSKILLED RESPITE CARE NOT HOSPICE; PER 15 MIN | Home Health Care Services | Y | | PA required after 7 days per calendar year | |
| S5151 | UNSKILLED RESPITE CARE NOT HOSPICE; PER DIEM | Home Health Care Services | Y | | PA required after 7 days per calendar year | |
| S5165 | HOME MODIFICATIONS; PER SERVICE | Home Health Care Services | Y | | | |
| S9122 | HOM HLTH AIDE/CERT NURSE ASST PROV CARE HOM; /HR | Home Health Care Services | Y | | | |
| S9123 | NURSING CARE THE HOME; REGISTERED NURSE PER HOUR | Home Health Care Services | Y | | | |
| S9124 | NURSING CARE IN THE HOME; BY LPN PER HOUR | Home Health Care Services | Y | | | |
| S9128 | SPEECH THERAPY IN THE HOME PER DIEM | Home Health Care Services | Y | | | |
| S9129 | OCCUPATIONAL THERAPY IN THE HOME PER DIEM | Home Health Care Services | Y | | | |
| S9131 | PHYSICAL THERAPY; IN THE HOME PER DIEM | Home Health Care Services | Y | | | |
| S9977 | MEALS PER DIEM NOT OTHERWISE SPECIFIED | Home Health Care Services | Y | | | |
| T1002 | RN SERVICES UP TO 15 MINUTES | Home Health Care Services | Y | | | |
| T1003 | LPN LVN SERVICES UP TO 15 MINUTES | Home Health Care Services | Y | | | |
| T1005 | RESPITE CARE SERVICES UP TO 15 MINUTES | Home Health Care Services | Y | | PA required after 7 days per calendar year | |
| T1022 | CONTRACT HOME HEALTH SRVC UNDER CONTRACT DAY | Home Health Care Services | Y | | | |
| T1030 | NURSING CARE IN THE HOME RN PER DIEM | Home Health Care Services | Y | | | |
| T1031 | NURSING CARE IN THE HOME BY LPN PER DIEM | Home Health Care Services | Y | | | |
| A2036 | COHEALYX COL DML MX PR SQ CM | Hyperbaric and Wound Care | Y | | | |
| A2037 | G4DERM PLUS, PER ML | Hyperbaric and Wound Care | Y | | | |
| A2038 | MARIGEN PACTO, PER SQ CM | Hyperbaric and Wound Care | Y | | | |
| A2039 | INNOVAMATRIX FD, PER SQ CM | Hyperbaric and Wound Care | Y | | | |
| Q4116 | ALLODERM PER SQ CM | Hyperbaric and Wound Care | Y | | | |
| Q4368 | AMCHOTHICK, PER SQUARE CENTIMETER | Hyperbaric and Wound Care | Y | | | |
| Q4369 | AMNIOPLAST 3, PER SQUARE CENTIMETER | Hyperbaric and Wound Care | Y | | | |
| Q4370 | AEROGUARD, PER SQUARE CENTIMETER” | Hyperbaric and Wound Care | Y | | | |
| Q4371 | NEOGUARD, PER SQUARE CENTIMETER | Hyperbaric and Wound Care | Y | | | |
| Q4372 | AMCHOPLAST EXCEL, PER SQUARE CENTIMETER | Hyperbaric and Wound Care | Y | | | |
| Q4373 | MEMBRANE WRAP-LITE, PER SQUARE CENTIMETER | Hyperbaric and Wound Care | Y | | | |
| Q4375 | DUOGRAFT AC, PER SQUARE CENTIMETER | Hyperbaric and Wound Care | Y | | | |
| Q4376 | DUOGRAFT AA, PER SQUARE CENTIMETER | Hyperbaric and Wound Care | Y | | | |
| Q4377 | TRIGRAFT FT, PER SQUARE CENTIMETER | Hyperbaric and Wound Care | Y | | | |
| Q4378 | RENEW FT MATRIX, PER SQUARE CENTIMETER | Hyperbaric and Wound Care | Y | | | |
| Q4379 | AMNIODEFEND FT MATRIX, PER SQUARE CENTIMETER | Hyperbaric and Wound Care | Y | | | |
| Q4380 | ADVOGRAFT ONE, PER SQUARE CENTIMETER | Hyperbaric and Wound Care | Y | | | |
| Q4382 | ADVOGRAFT DUAL, PER SQUARE CENTIMETER | Hyperbaric and Wound Care | Y | | | |
| Q4383 | AXOLOTL GRAFT ULT PER SQ CM | Hyperbaric and Wound Care | Y | | | |
| Q4384 | AXOLOTL DUAL ULT PER SQ CM | Hyperbaric and Wound Care | Y | | | |
| Q4385 | APOLLO FT PER SQ CM | Hyperbaric and Wound Care | Y | | | |
| Q4386 | ACESSO TRIFACA PER SQ CM | Hyperbaric and Wound Care | Y | | | |
| Q4387 | NEOTHELIUM FT PER SQ CM | Hyperbaric and Wound Care | Y | | | |
| Q4388 | NEOTHELIUM 4L PER SQ CM | Hyperbaric and Wound Care | Y | | | |

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|---|---|---|---|---|---|---|
| Q4389 | NEOTHELIUM 4L+ PER SQ CM | Hyperbaric and Wound Care | Y | | | |
| Q4390 | ASCENDION PER SQ CM | Hyperbaric and Wound Care | Y | | | |
| Q4391 | AMNIOPLAST DOUBLE PER SQ CM | Hyperbaric and Wound Care | Y | | | |
| Q4392 | GRAFIX DUO PER SQ CM | Hyperbaric and Wound Care | Y | | | |
| Q4393 | SURGRAFT AC PER SQ CM | Hyperbaric and Wound Care | Y | | | |
| Q4394 | SURGRAFT ACA PER SQ CM | Hyperbaric and Wound Care | Y | | | |
| Q4395 | ACELAGRAFT PER SQ CM | Hyperbaric and Wound Care | Y | | | |
| Q4396 | NATALIN PER SQ CM | Hyperbaric and Wound Care | Y | | | |
| Q4397 | SUMMIT AAA PER SQ CM | Hyperbaric and Wound Care | Y | | | |
| 15271 | APP SKN SUB GRFT T/A/L AREA/100SQ CM OR LT 1ST 25 | Hyperbaric/Wound Therapy | Y | | | |
| 15272 | APP SKN SUB GRFT T/A/L AREA/100SQ CM EA ADL 25SC | Hyperbaric/Wound Therapy | Y | | | |
| 15273 | APP SKN SUBGRFT T/A/L AREA/100SQ CM 1ST 100SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| 15274 | APP SKN SUB GRFT T/A/L AREA GT or equal to 100SCM ADL 100S | Hyperbaric/Wound Therapy | Y | | | |
| 15275 | SUB GRFT F/S/N/H/F/G/M/D LT 100SQ CM 1ST 25 SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| 15276 | SUB GRFT F/S/N/H/F/G/M/D LT 100SQ CM EA ADDL25SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| 15277 | SUB GRFT F/S/N/H/F/G/M/D GT or equal to 100SCM 1ST 100SQ | Hyperbaric/Wound Therapy | Y | | | |
| 15278 | SUB GRFT F/S/N/H/F/G/M/D GT or equal to 100SCM ADL 100SQ | Hyperbaric/Wound Therapy | Y | | | |
| 99183 | PHYS QHP ATTN AND SUPVJ HYPRBARIC OXYGEN TX SESSION | Hyperbaric/Wound Therapy | Y | | | |
| A2001 | INNOVAMATRIX AC PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| A2002 | MIRRAGEN ADVANCED WOUND MATRIX PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| A2004 | XCELLISTEM, 1 MG | Hyperbaric/Wound Therapy | Y | | | |
| A2005 | MICROLYTE MATRIX PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| A2006 | NOVOSORB SYNPATH PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| A2007 | RESTRATA, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| A2008 | THERAGENESIS, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| A2009 | SYMPHONY, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| A2010 | APIS, PER SQUARE CENTIMETER | Hyperbaric/Wound Therapy | Y | | | |
| A2011 | SUPRA SDRM, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| A2012 | SUPRATHEL, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| A2013 | INNOVAMATRIX FS, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| A2019 | KERECIS OMEGA3 MARIGEN SHIELD PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| A2020 | AC5 ADVANCED WOUND SYSTEM | Hyperbaric/Wound Therapy | Y | | | |
| A2021 | NEOMATRIX PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| A2030 | MIRO3D FIBERS, PER MG | Hyperbaric/Wound Therapy | Y | | | |
| A2031 | MIRODRY, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| A2032 | MYRIAD MATRIX, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| A2033 | MYRIAD MORCELLS, 4 MG | Hyperbaric/Wound Therapy | Y | | | |
| A2034 | FOUND DRS SOLO, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| A2035 | CORPL P THERAC P ALLAC P MG | Hyperbaric/Wound Therapy | Y | | | |
| A4100 | SKIN SUB FDA CLRD AS DEV NOS | Hyperbaric/Wound Therapy | Y | | | |
| C9250 | ARTISS FIBRIN SEALANT | Hyperbaric/Wound Therapy | Y | | | |
| G0277 | HPO UND PRESS FULL BODY CHMBR PER 30 MIN INT | Hyperbaric/Wound Therapy | Y | | | |
| Q4101 | APLIGRAF PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4102 | OASIS WOUND MATRIX | Hyperbaric/Wound Therapy | Y | | | |
| Q4103 | OASIS BURN MATRIX | Hyperbaric/Wound Therapy | Y | | | |
| Q4104 | INTEGRA BMWD | Hyperbaric/Wound Therapy | Y | | | |
| Q4105 | INTEGRA DRT OR OMNIGRAFT | Hyperbaric/Wound Therapy | Y | | | |
| Q4106 | DERMAGRAFT PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4107 | GRAFTJACKET | Hyperbaric/Wound Therapy | Y | | | |
| Q4108 | INTEGRA MATRIX | Hyperbaric/Wound Therapy | Y | | | |

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|---|---|---|---|---|---|---|
| Q4110 | PRIMATRIX | Hyperbaric/Wound Therapy | Y | | | |
| Q4111 | GAMMAGRAFT | Hyperbaric/Wound Therapy | Y | | | |
| Q4112 | CYMETRA INJECTABLE | Hyperbaric/Wound Therapy | Y | | | |
| Q4113 | GRAFTJACKET XPRESS | Hyperbaric/Wound Therapy | Y | | | |
| Q4114 | INTEGRA FLOWABLE WOUND MATRI | Hyperbaric/Wound Therapy | Y | | | |
| Q4115 | ALLOSKIN | Hyperbaric/Wound Therapy | Y | | | |
| Q4117 | HYALOMATRIX | Hyperbaric/Wound Therapy | Y | | | |
| Q4118 | MATRISTEM MICROMATRIX | Hyperbaric/Wound Therapy | Y | | | |
| Q4121 | THERASKIN PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4122 | DERMACELL, AWM, POROUS SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4123 | ALLOSKIN | Hyperbaric/Wound Therapy | Y | | | |
| Q4124 | OASIS TRI-LAYER WOUND MATRIX | Hyperbaric/Wound Therapy | Y | | | |
| Q4125 | ARTHROFLEX PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4126 | MEMODERM DERMASPAN TRANZGRFT INTEGUPLY PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4127 | TALYMED | Hyperbaric/Wound Therapy | Y | | | |
| Q4128 | FLEXHD ALLOPATCHHD OR MATRIX HD PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4130 | STRATTICE PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4132 | GRAFIX CORE AND GRAFIXPL CORE PER SQUARE CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4133 | GRAFIX PRIME AND GRAFIXPL PRIME PER SQUARE CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4134 | HMATRIX | Hyperbaric/Wound Therapy | Y | | | |
| Q4135 | MEDISKIN | Hyperbaric/Wound Therapy | Y | | | |
| Q4136 | EZDERM | Hyperbaric/Wound Therapy | Y | | | |
| Q4137 | AMNIOEXCEL BIODEXCEL 1SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4138 | BIODFENCE DRYFLEX, 1CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4139 | AMNIO OR BIODMATRIX, INJ 1CC | Hyperbaric/Wound Therapy | Y | | | |
| Q4140 | BIODFENCE 1CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4141 | ALLOSKIN AC, 1 CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4142 | XCM BIOLOGIC TISS MATRIX 1CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4143 | REPRIZA, 1CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4145 | EPIFIX, INJ, 1MG | Hyperbaric/Wound Therapy | Y | | | |
| Q4146 | TENSIX, 1CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4147 | ARCHITECT ECM PX FX 1 SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4148 | NEOX NEOX RT OR CLARIX CORD | Hyperbaric/Wound Therapy | Y | | | |
| Q4149 | EXCELLAGEN, 0.1 CC | Hyperbaric/Wound Therapy | Y | | | |
| Q4150 | ALLOWRAP DS OR DRY PER SQUARE CENTIMETER | Hyperbaric/Wound Therapy | Y | | | |
| Q4151 | AMNIOBAND OR GUARDIAN PER SQUARE CENTIMETER | Hyperbaric/Wound Therapy | Y | | | |
| Q4152 | DERMAPURE 1 SQUARE CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4153 | DERMAVEST, PLURIVEST SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4154 | BIOVANCE 1 SQUARE CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4155 | NEOXFLO OR CLARIXFLO 1 MG | Hyperbaric/Wound Therapy | Y | | | |
| Q4156 | NEOX 100 OR CLARIX 100 PER SQUARE CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4157 | REVITALON PER SQUARE CENTIMETER | Hyperbaric/Wound Therapy | Y | | | |
| Q4158 | KERECIS OMEGA3 PER SQUARE CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4159 | AFFINITY PER SQUARE CENTIMETER | Hyperbaric/Wound Therapy | Y | | | |
| Q4160 | NUSHIELD PER SQUARE CENTIMETER | Hyperbaric/Wound Therapy | Y | | | |
| Q4161 | BIO-CONNEKT PER SQUARE CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4162 | WOUNDEX FLOW BIOSKIN FLOW 0.5 CC | Hyperbaric/Wound Therapy | Y | | | |
| Q4163 | WOUNDEX BIOSKIN PER SQUARE CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4164 | HELICOLL PER SQUARE CENTIMETER | Hyperbaric/Wound Therapy | Y | | | |
| Q4165 | KERAMATRIX, KERASORB SQ CM | Hyperbaric/Wound Therapy | Y | | | |

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|---|---|---|---|---|---|---|
| Q4166 | CYTAL, PER SQUARE CENTIMETER | Hyperbaric/Wound Therapy | Y | | | |
| Q4167 | TRUSKIN, PER SQ CENTIMETER | Hyperbaric/Wound Therapy | Y | | | |
| Q4168 | AMNIOBAND, 1 MG | Hyperbaric/Wound Therapy | Y | | | |
| Q4169 | ARTACENT WOUND, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4170 | CYGNUS, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4171 | INTERFYL, 1 MG | Hyperbaric/Wound Therapy | Y | | | |
| Q4173 | PALINGEN OR PALINGEN XPLUS | Hyperbaric/Wound Therapy | Y | | | |
| Q4174 | PALINGEN OR PROMATRX | Hyperbaric/Wound Therapy | Y | | | |
| Q4175 | MIRODERM | Hyperbaric/Wound Therapy | Y | | | |
| Q4176 | NEOPATCH OR THERION, 1 SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4177 | FLOWERAMNIOFLO, 0.1 CC | Hyperbaric/Wound Therapy | Y | | | |
| Q4178 | FLOWERAMNIOPATCH PER SQUARE CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4179 | FLOWERDERM PER SQUARE CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4180 | REVITA PER SQUARE CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4181 | AMNIO WOUND PER SQUARE CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4182 | TRANSCYTE PER SQUARE CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4183 | SURGIGRAFT, 1 SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4184 | CELLESTA OR DUO PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4185 | CELLESTA FLOWAB AMNION 0.5CC | Hyperbaric/Wound Therapy | Y | | | |
| Q4186 | EPIFIX PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4187 | EPICORD PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4188 | AMNIOARMOR 1 SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4189 | ARTACENT AC, 1 MG | Hyperbaric/Wound Therapy | Y | | | |
| Q4190 | ARTACENT AC 1 SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4191 | RESTORIGIN, PER SQUARE CENTIMETER | Hyperbaric/Wound Therapy | Y | | | |
| Q4192 | RESTORIGIN, 1 CC | Hyperbaric/Wound Therapy | Y | | | |
| Q4193 | COLL-E-DERM 1 SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4194 | NOVACHOR PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4195 | PURAPLY PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4196 | PURAPLY AM PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4197 | PURAPLY XT PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4198 | GENESIS AMNIO MEMBRANE 1SQCM | Hyperbaric/Wound Therapy | Y | | | |
| Q4200 | SKIN TE 1 SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4201 | MATRION 1 SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4202 | KEROXX (2.5G/CC), 1CC | Hyperbaric/Wound Therapy | Y | | | |
| Q4203 | DERMA-GIDE PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4204 | XWRAP PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4205 | MEMBRANE GRAFT OR MEMBRANE WRAP PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4206 | FLUID FLOW OR FLUID GF 1 CC | Hyperbaric/Wound Therapy | Y | | | |
| Q4208 | NOVAFIX PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4209 | SURGRAFT PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4211 | AMNION BIO OR AXOBIO SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4212 | ALLOGEN, PER CC | Hyperbaric/Wound Therapy | Y | | | |
| Q4213 | ASCENT, 0.5 MG | Hyperbaric/Wound Therapy | Y | | | |
| Q4214 | CELLESTA CORD PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4215 | AXOLOTL AMBIENT OR AXOLOTL CRYO 0.1 MG | Hyperbaric/Wound Therapy | Y | | | |
| Q4216 | ARTACENT CORD PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4217 | WOUNDFIX BIOWOUND PLUS XPLUS | Hyperbaric/Wound Therapy | Y | | | |
| Q4218 | SURGICORD PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4219 | SURGIGRAFT-DUAL PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |

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|---|---|---|---|---|---|---|
| Q4220 | BELLACELL HD, SUREDERM SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4221 | AMNIO WRAP2 PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4222 | PROGENAMATRIX, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4224 | HHF10-P PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4225 | AMNIO OR DERMA TL, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4226 | MYOWN HARV PREP PROC SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4227 | AMNIOCORE, PER SQUARE CENTIMETER | Hyperbaric/Wound Therapy | Y | | | |
| Q4229 | COGENEX AMNIOTIC MEMBRANE, PER SQUARE CENTIMETER | Hyperbaric/Wound Therapy | Y | | | |
| Q4230 | COGENEX FLOW AMNION 0.5 CC | Hyperbaric/Wound Therapy | Y | | | |
| Q4231 | CORPLEX P PER CC | Hyperbaric/Wound Therapy | Y | | | |
| Q4232 | CORPLEX, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4233 | SURFACTOR /NUDYN PER 0.5 CC | Hyperbaric/Wound Therapy | Y | | | |
| Q4234 | XCELLERATE, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4235 | AMNIOREPAIR OR ALTIPLY SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4236 | CAREPATCH, PER SQUARE CENTIMETER | Hyperbaric/Wound Therapy | Y | | | |
| Q4237 | CRYO-CORD, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4238 | DERM-MAXX PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4239 | AMNIO-MAXX OR AMNIO-MAXX LITE PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4240 | CORECYTE FOR TOPICAL USE ONLY PER 0.5 CC | Hyperbaric/Wound Therapy | Y | | | |
| Q4241 | POLYCYTE, TOPICAL ONLY 0.5CC | Hyperbaric/Wound Therapy | Y | | | |
| Q4242 | AMNIOCYTE PLUS, PER 0.5 CC | Hyperbaric/Wound Therapy | Y | | | |
| Q4245 | AMNIOTEXT, PER CC | Hyperbaric/Wound Therapy | Y | | | |
| Q4246 | CORETEXT OR PROTEXT, PER CC | Hyperbaric/Wound Therapy | Y | | | |
| Q4247 | AMNIOTEXT PATCH, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4248 | DERMACYTE AMNIOTIC MEMBRANE ALLOGRAFT, PER SQUARE CENTIMETER | Hyperbaric/Wound Therapy | Y | | | |
| Q4249 | AMNIPLY, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4250 | AMNIOAMP-MP, PER SQUARE CENTIMETER | Hyperbaric/Wound Therapy | Y | | | |
| Q4252 | VENDAJE PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4254 | NOVAFIX DL PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4255 | REGUARD, TOPICAL USE PER SQ | Hyperbaric/Wound Therapy | Y | | | |
| Q4256 | MLG COMPLET, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4257 | RELESE, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4258 | ENVERSE, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4262 | DUAL LAYER IMPAX MEMBRANE PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4263 | SURGRAFT TL, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4264 | COCOON MEMBRANE, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4265 | NEOSTIM TL, PER SQUARE CENTIMETER | Hyperbaric/Wound Therapy | Y | | | |
| Q4266 | NEOSTIM MEMBRANE, PER SQUARE CENTIMETER | Hyperbaric/Wound Therapy | Y | | | |
| Q4267 | NEOSTIM DL, PER SQUARE CENTIMETER | Hyperbaric/Wound Therapy | Y | | | |
| Q4268 | SURGRAFT FT, PER SQUARE CENTIMETER | Hyperbaric/Wound Therapy | Y | | | |
| Q4269 | SURGRAFT XT, PER SQUARE CENTIMETER | Hyperbaric/Wound Therapy | Y | | | |
| Q4270 | COMPLETE SL, PER SQUARE CENTIMETER | Hyperbaric/Wound Therapy | Y | | | |
| Q4271 | COMPLETE FT, PER SQUARE CENTIMETER | Hyperbaric/Wound Therapy | Y | | | |
| Q4272 | ESANO A, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4273 | ESANO AAA, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4274 | ESANO AC, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4275 | ESANO ACA, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4276 | ORION, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4278 | EPIEFFECT, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |

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|---|---|---|---|---|---|---|
| Q4279 | VENDAJE AC, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4280 | XCELL AMNIO MATRIX, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4281 | BARRERA SL OR BARRERA DL, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4282 | CYGNUS DUAL, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4283 | BIOVANCE TRI-LAYER OR BIOVANCE 3L, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4284 | DERMABIND SL, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4287 | DERMABIND DL, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4288 | DERMABIND CH, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4289 | REVOSHIELD+ AMNIO, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4290 | MEMBRANE WRAP HYDR PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4291 | LAMELLAS XT, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4292 | LAMELLAS, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4293 | ACESSO DL, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4294 | AMNIO QUAD-CORE PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4295 | AMNIO TRI-CORE AMNIOTIC PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4296 | REBOUND MATRIX, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4297 | EMERGE MATRIX, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4298 | AMNICORE PRO, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4299 | AMNICORE PRO Plus PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4300 | ACESSO TL, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4301 | ACTIVATE MATRIX, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4302 | COMPLETE ACA PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4303 | COMPLETE AA, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4304 | GRAFIX PLUS, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4311 | ACESSO, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4312 | ACESSO AC, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4313 | DERMABIND FM, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4314 | REEVA, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4315 | REGENELINK AMNIOTIC MEM ALLO | Hyperbaric/Wound Therapy | Y | | | |
| Q4316 | AMCHOPLAST PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4317 | VITOGRAFT, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4318 | E-GRAFT, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4319 | SANOGRAFT, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4320 | PELLOGRAFT, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4321 | RENOGRAFT, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4322 | CAREGRAFT, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4323 | ALLOPLY, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4324 | AMNIOTX, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4325 | ACAPATCH, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4326 | WOUNDPLUS, PER SQUARE CENTIMETER | Hyperbaric/Wound Therapy | Y | | | |
| Q4327 | DUOAMNION, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4328 | MOST, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4329 | SINGLAY, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4330 | TOTAL, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4331 | AXOLOTL GRAFT, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4332 | AXOLOTL DUALGRAFT, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4333 | ARDEOGRAFT, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4334 | AMNIOPLAST 1, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4335 | AMNIOPLAST 2, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4336 | ARTECENT C, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |

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|---|---|---|---|---|---|---|
| Q4337 | ARTECENT TRIDENT, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4338 | ARTACENT VELOS, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4339 | ARTACENT VERICLEN, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4340 | SIMPLIGRAFT, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4341 | SIMPLIMAX, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4342 | THERAMEND, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4343 | DERMACYTE AC MATRX PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4344 | TRI MEMBRANE WRAP, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4345 | MATRIX HD ALLOGRFT PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4346 | SHELTER DM MATRIX PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4347 | RAMPART DL MATRIX PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4348 | SENTRY SL MATRIX PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4349 | MANTLE DL MATRIX PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4350 | PALISADE DM MATRIX PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4351 | ENCLOSE TL MATRIX, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4352 | OVERLAY SL MATRIX, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4353 | XCEED TL MATRIX PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4355 | ABIO XPL ABIO XPL HY P SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4356 | ABIO MEM ABIO HYD PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4357 | XWRAP PLUS, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4358 | XWRAP DUAL, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4359 | CHORIPLY, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4361 | EPIXPRESS, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4362 | CYGNUS DISK, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4363 | AM BUR MEM HYDRO PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4364 | AM BUR XP MEM XPL HY P SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4365 | AMNIO BUR DL MEM PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4366 | DL AMNIO BUR X-MEM PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| Q4367 | AMNIOCORE SL, PER SQ CM | Hyperbaric/Wound Therapy | Y | | | |
| 70336 | MRI TEMPOROMANDIBULAR JOINT | Imaging & Special Tests | Y | | | |
| 70450 | CT HEAD BRAIN W O CONTRAST MATERIAL | Imaging & Special Tests | Y | | | |
| 70460 | CT HEAD BRAIN W CONTRAST MATERIAL | Imaging & Special Tests | Y | | | |
| 70470 | CT HEAD BRAIN W O AND W CONTRAST MATERIAL | Imaging & Special Tests | Y | | | |
| 70496 | CT ANGIOGRAPHY HEAD W CONTRAST NONCONTRAST | Imaging & Special Tests | Y | | | |
| 70498 | CT ANGIOGRAPHY NECK W CONTRAST NONCONTRAST | Imaging & Special Tests | Y | | | |
| 70540 | MRI ORBIT FACE AND NECK W O CONTRAST | Imaging & Special Tests | Y | | | |
| 70542 | MRI ORBIT FACE AND NECK W CONTRAST MATERIAL | Imaging & Special Tests | Y | | | |
| 70543 | MRI ORBIT FACE AND NECK W O AND W CONTRAST MATRL | Imaging & Special Tests | Y | | | |
| 70544 | MRA HEAD W O CONTRST MATERIAL | Imaging & Special Tests | Y | | | |
| 70545 | MRA HEAD W CONTRAST MATERIAL | Imaging & Special Tests | Y | | | |
| 70546 | MRA HEAD W O AND W CONTRAST MATERIAL | Imaging & Special Tests | Y | | | |
| 70547 | MRA NECK W O CONTRST MATERIAL | Imaging & Special Tests | Y | | | |
| 70548 | MRA NECK W CONTRAST MATERIAL | Imaging & Special Tests | Y | | | |
| 70549 | MRA NECK W O AND W CONTRAST MATERIAL | Imaging & Special Tests | Y | | | |
| 70551 | MRI BRAIN BRAIN STEM W O CONTRAST MATERIAL | Imaging & Special Tests | Y | | | |
| 70552 | MRI BRAIN BRAIN STEM W CONTRAST MATERIAL | Imaging & Special Tests | Y | | | |
| 70553 | MRI BRAIN BRAIN STEM W O W CONTRAST MATERIAL | Imaging & Special Tests | Y | | | |
| 70554 | MRI BRAIN FUNCTIONAL W O PHYSICIAN ADMNISTRATION | Imaging & Special Tests | Y | | | |
| 70555 | MRI BRAIN FUNCTIONAL W PHYSICIAN ADMNISTRATION | Imaging & Special Tests | Y | | | |
| 71275 | CT ANGIOGRAPHY CHEST W CONTRAST NONCONTRAST | Imaging & Special Tests | Y | | | |

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|---|---|---|---|---|---|---|
| 71550 | MRI CHEST W O CONTRAST MATERIAL | Imaging & Special Tests | Y | | | |
| 71551 | MRI CHEST W CONTRAST MATERIAL | Imaging & Special Tests | Y | | | |
| 71552 | MRI CHEST W O AND W CONTRAST MATERIAL | Imaging & Special Tests | Y | | | |
| 71555 | MRA CHEST W O AND W CONTRAST MATERIAL | Imaging & Special Tests | Y | | | |
| 72128 | CT THORACIC SPINE W O CONTRAST MATERIAL | Imaging & Special Tests | Y | | | |
| 72129 | CT THORACIC SPINE W CONTRAST MATERIAL | Imaging & Special Tests | Y | | | |
| 72130 | CT THORACIC SPINE W O AND W CONTRAST MTRL | Imaging & Special Tests | Y | | | |
| 72131 | CT LUMBAR SPINE W O CONTRAST MATERIAL | Imaging & Special Tests | Y | | | |
| 72132 | CT LUMBAR SPINE W CONTRAST MATERIAL | Imaging & Special Tests | Y | | | |
| 72133 | CT LUMBAR SPINE W O AND W CONTRAST MATERIAL | Imaging & Special Tests | Y | | | |
| 72141 | MRI SPINAL CANAL CERVICAL W O CONTRAST MATRL | Imaging & Special Tests | Y | | | |
| 72142 | MRI SPINAL CANAL CERVICAL W CONTRAST MATRL | Imaging & Special Tests | Y | | | |
| 72146 | MRI SPINAL CANAL THORACIC W O CONTRAST MATRL | Imaging & Special Tests | Y | | | |
| 72147 | MRI SPINAL CANAL THORACIC W CONTRAST MATRL | Imaging & Special Tests | Y | | | |
| 72148 | MRI SPINAL CANAL LUMBAR W O CONTRAST MATERIAL | Imaging & Special Tests | Y | | | |
| 72149 | MRI SPINAL CANAL LUMBAR W CONTRAST MATERIAL | Imaging & Special Tests | Y | | | |
| 72156 | MRI SPINAL CANAL CERVICAL WO AND W CONTR MTRL | Imaging & Special Tests | Y | | | |
| 72157 | MRI SPINAL CANAL THORACIC WO FF BY W CNTRST MTRL | Imaging & Special Tests | Y | | | |
| 72158 | MRI SPINAL CANAL LUMBAR WO FF BY W CNTRST MTRL | Imaging & Special Tests | Y | | | |
| 72159 | MRA SPINAL CANAL W WO CONTRAST MATERIAL | Imaging & Special Tests | Y | | | |
| 72191 | CT ANGIOGRAPHY PELVIS W CONTRAST NONCONTRAST | Imaging & Special Tests | Y | | | |
| 72192 | CT PELVIS W O CONTRAST MATERIAL | Imaging & Special Tests | Y | | | |
| 72193 | CT PELVIS W CONTRAST MATERIAL | Imaging & Special Tests | Y | | | |
| 72194 | CT PELVIS W O AND W CONTRAST MATERIAL | Imaging & Special Tests | Y | | | |
| 72195 | MRI PELVIS W O CONTRAST MATERIAL | Imaging & Special Tests | Y | | | |
| 72196 | MRI PELVIS W CONTRAST MATERIAL | Imaging & Special Tests | Y | | | |
| 72197 | MRI PELVIS W O AND W CONTRAST MATERIAL | Imaging & Special Tests | Y | | | |
| 72198 | MRA PELVIS W WO CONTRAST MATERIAL | Imaging & Special Tests | Y | | | |
| 73218 | MRI UPPER EXTREMITY OTH THAN JT W O CONTR MATRL | Imaging & Special Tests | Y | | | |
| 73219 | MRI UPPER EXTREMITY OTH THAN JT W CONTR MATRL | Imaging & Special Tests | Y | | | |
| 73220 | MRI UPPER EXTREM OTHER THAN JT W O AND W CONTRAS | Imaging & Special Tests | Y | | | |
| 73221 | MRI ANY JT UPPER EXTREMITY W O CONTRAST MATRL | Imaging & Special Tests | Y | | | |
| 73222 | MRI ANY JT UPPER EXTREMITY W CONTRAST MATRL | Imaging & Special Tests | Y | | | |
| 73223 | MRI ANY JT UPPER EXTREMITY W O AND W CONTR MATRL | Imaging & Special Tests | Y | | | |
| 73225 | MRA UPPER EXTREMITY W WO CONTRAST MATERIAL | Imaging & Special Tests | Y | | | |
| 73718 | MRI LOWER EXTREM OTH THN JT W O CONTR MATRL | Imaging & Special Tests | Y | | | |
| 73719 | MRI LOWER EXTREM OTH THN JT W CONTRAST MATRL | Imaging & Special Tests | Y | | | |
| 73720 | MRI LOWER EXTREM OTH THN JT W O AND W CONTR MATR | Imaging & Special Tests | Y | | | |
| 73721 | MRI ANY JT LOWER EXTREM W O CONTRAST MATRL | Imaging & Special Tests | Y | | | |
| 73722 | MRI ANY JT LOWER EXTREM W CONTRAST MATERIAL | Imaging & Special Tests | Y | | | |
| 73723 | MRI ANY JT LOWER EXTREM W O AND W CONTRAST MATRL | Imaging & Special Tests | Y | | | |
| 73725 | MRA LOWER EXTREMITY W WO CONTRAST MATERIAL | Imaging & Special Tests | Y | | | |
| 74150 | CT ABDOMEN W O CONTRAST MATERIAL | Imaging & Special Tests | Y | | | |
| 74160 | CT ABDOMEN W CONTRAST MATERIAL | Imaging & Special Tests | Y | | | |
| 74170 | CT ABDOMEN W O AND W CONTRAST MATERIAL | Imaging & Special Tests | Y | | | |
| 74174 | CT ANGIO ABD AND PLVIS CNTRST MTRL W WO CNTRST IMG | Imaging & Special Tests | Y | | | |
| 74175 | CT ANGIOGRAPHY ABDOMEN W CONTRAST NONCONTRAST | Imaging & Special Tests | Y | | | |
| 74176 | CT ABDOMEN AND PELVIS W O CONTRAST MATERIAL | Imaging & Special Tests | Y | | | |
| 74177 | CT ABDOMEN AND PELVIS W CONTRAST MATERIAL | Imaging & Special Tests | Y | | | |
| 74178 | CT ABDOMEN AND PELVIS W O CONTRST 1 OR GRT BODY RE | Imaging & Special Tests | Y | | | |

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| 74181 | MRI ABDOMEN W O CONTRAST MATERIAL | Imaging & Special Tests | Y | | | |
| 74182 | MRI ABDOMEN W CONTRAST MATERIAL | Imaging & Special Tests | Y | | | |
| 74183 | MRI ABDOMEN W O AND W CONTRAST MATERIAL | Imaging & Special Tests | Y | | | |
| 74185 | MRA ABDOMEN W WO CONTRAST MATERIAL | Imaging & Special Tests | Y | | | |
| 74261 | CT COLONOGRPHY DX IMAGE POSTPROCESS W O CONTRAST | Imaging & Special Tests | Y | | | |
| 74262 | CT COLONOGRPHY DX IMAGE POSTPROCESS W CONTRAST | Imaging & Special Tests | Y | | | |
| 74263 | CT COLONOGRAPHY SCREENING IMAGE POSTPROCESSING | Imaging & Special Tests | Y | | | |
| 75557 | CARDIAC MRI MORPHOLOGY & FUNCTION W/O CONTRAST | Imaging & Special Tests | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 75559 | CARDIAC MRI W O CONTRAST W STRESS IMAGING | Imaging & Special Tests | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 75561 | CARDIAC MRI W/WO CONTRAST & FURTHER SEQ | Imaging & Special Tests | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 75563 | CARDIAC MRI WO FF BY W CNTRST W STRESS IMGNG | Imaging & Special Tests | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 75571 | CT HEART NO CONTRAST QUANT EVAL CORONRY CALCIUM | Imaging & Special Tests | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 75572 | CT HEART CONTRAST EVAL CARDIAC STRUCTURE AND MORPH | Imaging & Special Tests | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 75573 | CT HRT CONTRST CARDIAC STRUCT&MORPH CONG HRT D | Imaging & Special Tests | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 75574 | CTA HRT CORNRY ART/BYPASS GRFTS CONTRST 3D POST | Imaging & Special Tests | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 75635 | CTA ABDL AORTA AND BI ILIOFEM W CONTRAST AND POSTP | Imaging & Special Tests | Y | | | |
| 76376 | 3D RENDERING W INTERP AND POSTPROCESS SUPERVISION | Imaging & Special Tests | Y | | If requesting identified code as a standalone code, please fax request to the healthplan. If requesting code with another imaging code, please fax request to (877) 731-7218. | |
| 76377 | 3D RENDERING W INTERP AND POSTPROC DIFF WORK STATION | Imaging & Special Tests | Y | | If submitting this code with another Advanced Imaging code, send request to Advanced Imaging. Otherwise, send request to the Health Plan. For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | |
| 76390 | MRI SPECTROSCOPY | Imaging & Special Tests | Y | | | |
| 76391 | MAGNETIC RESONANCE ELASTOGRAPHY | Imaging & Special Tests | Y | | | |
| 76497 | UNLISTED COMPUTED TOMOGRAPHY PROCEDURE | Imaging & Special Tests | Y | | | |
| 76498 | UNLISTED MAGNETIC RESONANCE PROCEDURE | Imaging & Special Tests | Y | | | |
| 77046 | MRI BREAST WITHOUT CONTRAST MATERIAL UNILATERAL | Imaging & Special Tests | Y | | | |
| 77047 | MRI BREAST WITHOUT CONTRAST MATERIAL BILATERAL | Imaging & Special Tests | Y | | | |
| 77048 | MRI BREAST W OUT AND WITH CONTRAST W CAD UNILATERAL | Imaging & Special Tests | Y | | | |
| 77049 | MRI BREAST WITHOUT AND WITH CONTRAST W CAD BILATERAL | Imaging & Special Tests | Y | | | |
| 78429 | MYOCRD IMG PET METAB EVAL SINGLE STUDY CNCRNT CT | Imaging & Special Tests | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |

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| 78430 | MYOCRD IMG PET PRFUJ 1STD REST STRESS CNCRNT CT | Imaging & Special Tests | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 78431 | MYOCRD IMG PET PRFUJ MLT STD RST AND STRS CNCRNT CT | Imaging & Special Tests | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 78432 | MYOCRD IMG PET PRFUJ W METAB DUAL RADIOTRACER | Imaging & Special Tests | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 78433 | MYOCRD IMG PET PRFUJ W METAB 2RTRACER CNCRNT CT | Imaging & Special Tests | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 78451 | MYOCARDIAL SPECT SINGLE STUDY AT REST OR STRESS | Imaging & Special Tests | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 78452 | MYOCARDIAL SPECT MULTIPLE STUDIES | Imaging & Special Tests | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 78453 | MYOCARDIAL PERFUSION PLANAR 1 STUDY REST/STRESS | Imaging & Special Tests | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 78454 | MYOCARDIAL PERFUSION PLANAR MULTIPLE STUDIES | Imaging & Special Tests | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 78459 | MYOCARDIAL IMAGING PET METABOLIC EVALUATION | Imaging & Special Tests | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 78466 | MYOCARDIAL IMAGING INFARCT AVID PLANAR QUAL/QUAN | Imaging & Special Tests | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 78468 | MYOCRD IMG INFARCT AVID PLNR EJEC FXJ 1ST PS TQ | Imaging & Special Tests | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 78469 | MYOCRD INFARCT AVID PLNR TOMOG SPECT W/WO QUANTJ | Imaging & Special Tests | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 78472 | CARD BLOOD POOL GATED PLANAR 1 STUDY REST/STRESS | Imaging & Special Tests | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 78473 | CARD BL POOL GATED MLT STDY WAL MOTN EJECT FRACT | Imaging & Special Tests | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 78481 | CARD BL POOL PLANAR 1 STDY WAL MOTN EJECT FRACT | Imaging & Special Tests | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 78483 | CARD BL POOL PLNR MLT STDY WAL MOTN EJECT FRACT | Imaging & Special Tests | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |

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| 78491 | MYOCRD IMAGE PET PERFUS SINGLE STUDY REST/STRESS | Imaging & Special Tests | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 78492 | MYOCRD IMAGE PET PERFUS MULTPL STUDY REST/STRESS | Imaging & Special Tests | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 78494 | CARD BL POOL GATED SPECT REST WAL MOTN EJCT FRCT | Imaging & Special Tests | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 78499 | UNLISTED CARDIOVASCULAR PX DX NUCLEAR MEDICINE | Imaging & Special Tests | Y | | | |
| 78608 | BRAIN IMAGING PET METABOLIC EVALUATION | Imaging & Special Tests | Y | | | |
| 78609 | BRAIN IMAGING PET PERFUSION EVALUATION | Imaging & Special Tests | Y | | | |
| 78811 | PET IMAGING LIMITED AREA CHEST HEAD NECK | Imaging & Special Tests | Y | | | |
| 78812 | PET IMAGING SKULL BASE TO MID-THIGH | Imaging & Special Tests | Y | | | |
| 78813 | PET IMAGING WHOLE BODY | Imaging & Special Tests | Y | | | |
| 78814 | PET IMAGING CT FOR ATTENUATION LIMITED AREA | Imaging & Special Tests | Y | | | |
| 78815 | PET IMAGING CT ATTENUATION SKULL BASE MID-THIGH | Imaging & Special Tests | Y | | | |
| 78816 | PET IMAGING FOR CT ATTENUATION WHOLE BODY | Imaging & Special Tests | Y | | | |
| 91113 | GI TRACT IMAGING INTRALUMINAL COLON I AND R | Imaging & Special Tests | Y | | | |
| 93241 | EXTERNAL ECG REC GT 48HR LT 7D SCAN ALYS REPORT R AND I | Imaging & Special Tests | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 93242 | EXTERNAL ECG REC GT 48HR LT 7D RECORDING | Imaging & Special Tests | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 93243 | EXTERNAL ECG REC GT 48HR LT 7D SCANNING ALYS W/REPORT | Imaging & Special Tests | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 93244 | EXTERNAL ECG REC GT 48HR LT 7D REVIEW AND INTERPRETATION | Imaging & Special Tests | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 93245 | EXTERNAL ECG REC GT 7D LT 15D SCAN ALYS REPORT R AND I | Imaging & Special Tests | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 93246 | EXTERNAL ECG REC GT 7D LT 15D RECORDING | Imaging & Special Tests | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 93247 | EXTERNAL ECG REC GT 7D LT 15D SCANNING ALYS W/REPORT | Imaging & Special Tests | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 93248 | EXTERNAL ECG REC GT 7D LT 15D REVIEW AND INTERPRETATION | Imaging & Special Tests | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 93895 | CAROTID INTIMA MEDIA & CAROTID ATHEROMA EVAL BI | Imaging & Special Tests | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 0331T | MYOCRD SYMPATHETIC INNERVAJ IMG PLNR QUAL AND QUANT | Imaging & Special Tests | Y | | | |
| 0332T | MYOCRD SYMP INNERVAJ IMG PLNR QUAL AND QUANT W SPECT | Imaging & Special Tests | Y | | | |
| 0609T | MRS DISC PAIN ACQUISJ DATA | Imaging & Special Tests | Y | | | |
| 0610T | MRS DISC PAIN TRANSMIS DATA | Imaging & Special Tests | Y | | | |

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|---|---|---|---|---|---|---|
| 0611T | MRS DISC PAIN ALG ALYS DATA | Imaging & Special Tests | Y | | | |
| 0612T | MRS DISCOGENIC PAIN I&R | Imaging & Special Tests | Y | | | |
| 0623T | AUTO QUAN AND CHARAC CORONARY ATHEROSCLEROTIC PLAQUE | Imaging & Special Tests | Y | | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | |
| 0624T | AUTO QUAN AND CHARAC CORONARY PLAQ DATA PREP AND TRNSMIS | Imaging & Special Tests | Y | | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | |
| 0625T | AUTO QUAN AND CHARAC CORONARY PLAQ COMPUTERIZED ALYS | Imaging & Special Tests | Y | | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | |
| 0626T | AUTO QUAN AND CHARAC CORONARY PLAQ REV CPTR ALYS I AND R | Imaging & Special Tests | Y | | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | |
| 0633T | CT BREAST W/3D RENDERING UNI WITHOUT CONTRAST | Imaging & Special Tests | Y | | | |
| 0634T | CT BREAST W/3D RENDERING UNI WITH CONTRAST | Imaging & Special Tests | Y | | | |
| 0635T | CT BRST W/3D RENDERING UNI WO CNTRST FLWD CNTRST | Imaging & Special Tests | Y | | | |
| 0636T | CT BREAST W/3D RENDERING BI WITHOUT CONTRAST | Imaging & Special Tests | Y | | | |
| 0637T | CT BREAST W/3D RENDERING BI WITH CONTRAST | Imaging & Special Tests | Y | | | |
| 0638T | CT BRST W/3D RENDERING BI WO CNTRST FLWD CNTRST | Imaging & Special Tests | Y | | | |
| 0689T | QUAN US TISS CHARAC I AND R W/O DX US SAME ANAT | Imaging & Special Tests | Y | | | |
| 0710T | N-INVAS ARTL PLAQ ALYS DATA PRP QUAN REVIEW I AND R | Imaging & Special Tests | Y | | | |
| 0711T | N-INVAS ARTL PLAQ ALYS DATA PREP AND TRANSMISSION | Imaging & Special Tests | Y | | | |
| 0712T | N-INVAS ARTL PLAQ ALYS QUAN STRUX AND COMPOS VSL WAL | Imaging & Special Tests | Y | | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | |
| 0713T | N-INVAS ARTL PLAQ ALYS DATA REVIEW I AND R | Imaging & Special Tests | Y | | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | |
| C8909 | MR ANGIOGRAPHY WITH CONTRAST CHEST | Imaging & Special Tests | Y | | | |
| C8910 | MR ANGIOGRAPHY WITHOUT CONTRAST CHEST | Imaging & Special Tests | Y | | | |
| 95700 | EEG CONT REC W VIDEO BY TECH MIN 8 CHANNELS | Neuropsychological and Psychological Tests | Y | | | |
| 95708 | EEG W O VID BY TECH EA INCR 12-26HR UNMONITORED | Neuropsychological and Psychological Tests | Y | | | |
| 95709 | EEG W O VID BY TECH EA INCR 12-26 HR INTMT MNTR | Neuropsychological and Psychological Tests | Y | | | |
| 95710 | EEG W O VID TECH EA INCR 12-26 HR CONT R-T MNTR | Neuropsychological and Psychological Tests | Y | | | |
| 95711 | VEEG BY TECH 2-12 HOURS UNMONITORED | Neuropsychological and Psychological Tests | Y | | | |
| 95712 | VEEG BY TECH 2-12 HR INTERMITTENT MONITORING | Neuropsychological and Psychological Tests | Y | | | |
| 95713 | VEEG BY TECH 2-12 HR CONTINUOUS R-T MONITORING | Neuropsychological and Psychological Tests | Y | | | |
| 95714 | VEEG BY TECH EA INCR 12-26 HR UNMONITORED | Neuropsychological and Psychological Tests | Y | | | |
| 95715 | VEEG BY TECH EA INCR 12-26 HR INTERMITTENT MNTR | Neuropsychological and Psychological Tests | Y | | | |
| 95716 | VEEG BY TECH EA INCR 12-26 HR CONT R-T MNTR | Neuropsychological and Psychological Tests | Y | | | |
| 95721 | EEG COMPLETE STD PHYS QHP OVER 36 HR UNDER 60 HR W O VIDEO | Neuropsychological and Psychological Tests | Y | | | |
| 95722 | EEG COMPLETE STD PHYS QHP OVER 36 HR UNDER 60 HR W VEEG | Neuropsychological and Psychological Tests | Y | | | |
| 95723 | EEG COMPLETE STD PHYS QHP OVER 60 HR UNDER 84 HR W O VIDEO | Neuropsychological and Psychological Tests | Y | | | |
| 95724 | EEG COMPLETE STD PHYS QHP OVER 60 HR UNDER 84 HR W VEEG | Neuropsychological and Psychological Tests | Y | | | |
| 95725 | EEG COMPLETE STD PHYS QHP OVER 84 HR W O VID | Neuropsychological and Psychological Tests | Y | | | |
| 95726 | EEG COMPLETE STD PHYS QHP OVER 84 HR W VEEG | Neuropsychological and Psychological Tests | Y | | | |
| 96125 | STANDARDIZED COGNITIVE PERFORMANCE TESTING | Neuropsychological and Psychological Tests | Y | | | |
| 96130 | PSYCHOLOGICAL TST EVAL SVC PHYS/QHP FIRST HOUR | Neuropsychological and Psychological Tests | Y | | Prior Auth required after initial 4 hours of testing per calendar year. | |
| 96131 | PSYCHOLOGICAL TST EVAL SVC PHYS/QHP EA ADDL HOUR | Neuropsychological and Psychological Tests | Y | | Prior Auth required after initial 4 hours of testing per calendar year. | |
| 96132 | NEUROPSYCHOLOGICAL TST EVAL PHYS/QHP 1ST HOUR | Neuropsychological and Psychological Tests | Y | | Prior Auth required after initial 4 hours of testing per calendar year. | |
| 96133 | NEUROPSYCHOLOGICAL TST EVAL PHYS/QHP EA ADDL HR | Neuropsychological and Psychological Tests | Y | | Prior Auth required after initial 4 hours of testing per calendar year. | |
| 96136 | PSYL/NRPSYCL TST PHYS/QHP 2 PLUS TST 1ST 30 MIN | Neuropsychological and Psychological Tests | Y | | Prior Auth required after initial 4 hours of testing per calendar year. | |
| 96137 | PSYCL/NRPSYCL TST PHYS/QHP 2 PLUS TST EA ADDL 30 MIN | Neuropsychological and Psychological Tests | Y | | Prior Auth required after initial 4 hours of testing per calendar year. | |
| 96138 | PSYCL NRPSYCL TST TECH 2 PLUS TST 1ST 30 MIN | Neuropsychological and Psychological Tests | Y | | Prior Auth required after initial 4 hours of testing per calendar year. | |
| 96139 | PSYCL NRPSYCL TST TECH 2 PLUS TST EA ADDL 30 MIN | Neuropsychological and Psychological Tests | Y | | Prior Auth required after initial 4 hours of testing per calendar year. | |

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| 15769 | GRAFTING OF AUTOLOGOUS SOFT TISS BY DIRECT EXC | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 15771 | GRAFTING OF AUTOLOGOUS FAT BY LIPO 50 CC OR LESS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 15773 | GRAFTING OF AUTOLOGOUS FAT BY LIPO 25 CC OR LESS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 15786 | ABRASION 1 LESION | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 15830 | EXCISION SKIN ABD INFRAUMBILICAL PANNICULECTOMY | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 17360 | CHEMICAL EXFOLIATION ACNE | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 20560 | NEEDLE INSERTION(S) WITHOUT INJ, 1 OR 2 MUSCLES | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 20561 | NEEDLE INSERTION(S) WITHOUT INJ, 3 OR MORE MUSCLES | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 21073 | MANIPULATION TMJ THERAPEUTIC REQUIRE ANESTHESIA | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 21120 | GENIOPLASTY AUGMENTATION | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 21121 | GENIOPLASTY SLIDING OSTEOTOMY SINGLE PIECE | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 21122 | GENIOPLASTY 2 OR GRT SLIDING OSTEOTOMIES | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 21123 | GENIOP SLIDING AGMNTJ W INTERPOSAL BONE GRAFTS | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 21125 | AGMNTJ MNDBLR BODY ANGLE PROSTHETIC MATERIAL | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 21127 | AGMNTJ MNDBLR BDY ANGL W GRF ONLAY INTERPOSAL | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 21137 | REDUCTION FOREHEAD CONTOURING ONLY | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 21138 | RDCTJ FHD CNTRG AND PROSTHETIC MATRL BONE GRAFT | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 21139 | RDCTJ FHD CNTRG AND SETBACK ANT FRONTAL SINUS WALL | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 21141 | RCNSTJ MIDFACE LEFORT I 1 PIECE W O BONE GRAFT | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 21142 | RCNSTN MIDFACE LEFORT I 2 PIECES W O BONE GRAFT | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 21143 | RCNSTN MIDFACE LEFORT I 3 OR GRT PIECE W O BONE GRAFT | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 21145 | RCNSTJ MIDFACE LEFORT I 1 PIECE W BONE GRAFTS | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 21146 | RCNSTJ MIDFACE LEFORT I 2 PIECES W BONE GRAFTS | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 21147 | RCNSTJ MIDFACE LEFORT I 3 OR GRT PIECE W BONE GRAFTS | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 21150 | RCNSTJ MIDFACE LEFORT II ANTERIOR INTRUSION | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 21151 | RCNSTJ MIDFACE LEFORT II W BONE GRAFTS | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 21154 | RCNSTJ MIDFACE LEFORT III W O LEFORT I | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 21155 | RCNSTJ MIDFACE LEFORT III W LEFORT I | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 21159 | RCNSTJ MIDFACE LEFORT III W FHD W O LEFORT I | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 21160 | RCNSTJ MIDFACE LEFORT III W FHD W LEFORT I | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 21172 | RCNSTJ SUPERIOR-LATERAL ORBITAL RIM AND LOWER FHD | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 21175 | RCNSTJ BIFRONTAL SUPERIOR-LAT ORB RIMS AND LWR FHD | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 21240 | ARTHRP TEMPOROMANDIBULAR JOINT W WO AUTOGRAFT | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 21242 | ARTHROPLASTY TEMPOROMANDIBULAR JT W ALLOGRAFT | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 21243 | ARTHRP TMPRMAND JOINT W PROSTHETIC REPLACEMENT | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 21270 | MALAR AUGMENTATION PROSTHETIC MATERIAL | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 21280 | MEDIAL CANTHOPEXY SEPARATE PROCEDURE | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 21282 | LATERAL CANTHOPEXY | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 21295 | REDUCTION MASSETER MUSCLE AND BONE EXTRAORAL | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 21296 | REDUCTION MASSETER MUSCLE AND BONE INTRAORAL | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 21601 | EXCISION OF CHEST WALL TUMOR INCLUDING RIB(S) | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 21602 | EXCISION CH WAL TUM W/RIB W/O MEDSTNL LYMPHADEC | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 21603 | EXCISION CH WAL TUM W/RIB W/MEDSTNL LYMPHADEC | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |

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|---|---|---|---|---|---|---|
| 21620 | OSTECTOMY STERNUM PARTIAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 21627 | STERNAL DEBRIDEMENT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 21630 | RADICAL RESECTION STERNUM | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 21750 | CLOSE MEDIAN STERNOTOMY SEP W/WO DEBRIDEMENT SPX | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 22100 | PRTL EXC PST VRT INTRNSC B1Y LES 1 VRT SGM CRV | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22101 | PRTL EXC PST VRT INTRNSC B1Y LES 1 VRT SGM THRC | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22102 | PRTL EXC PST VRT INTRNSC B1Y LES 1 VRT SGM LMBR | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22110 | PRTL EXC VRT BDY B1Y LES W O SPI CORD 1 SGM CRV | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22112 | PRTL EXC VRT BDY B1Y LES W O SPI CORD 1 SGM THRC | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22114 | PRTL EXC VRT BDY B1Y LES W O SPI CORD 1 SGM LMBR | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22206 | OSTEOTOMY SPINE POSTERIOR 3 COLUMN THORACIC | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22207 | OSTEOTOMY SPINE POSTERIOR 3 COLUMN LUMBAR | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22210 | OSTEOTOMY SPINE PST PSTLAT APPR 1 VRT SGM CRV | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22212 | OSTEOTOMY SPINE PST PSTLAT APPR 1 VRT SGM THRC | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22214 | OSTEOTOMY SPINE PST PSTLAT APPR 1 VRT SGM LMBR | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22220 | OSTEOTOMY SPINE W DSKC ANT APPR 1 VRT SGM CRV | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22222 | OSTEOTOMY SPINE W DSKC ANT APPR 1 VRT SGM THRC | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22224 | OSTEOTOMY SPINE W DSKC ANT APPR 1 VRT SGM LMBR | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22526 | PERQ INTRDSCL ELECTROTHRM ANNULOPLASTY 1 LEVEL | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22527 | PERQ INTRDSCL ELECTROTHRM ANNULOPLASTY ADDL LVL | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22532 | ARTHRODESIS LATERAL EXTRACAVITARY THORACIC | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22533 | ARTHRODESIS LATERAL EXTRACAVITARY LUMBAR | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22548 | ARTHRD ANT TRANSORL XTRORAL C1-C2 W WO EXC ODNTD | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22551 | ARTHRD ANT INTERBODY DECOMPRESS CERVICAL BELW C2 | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22552 | ARTHRD ANT INTERDY CERVCL BELW C2 EA ADDL NTRSPC | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 22554 | ARTHRD ANT MIN DISCECT INTERBODY CERV BELOW C2 | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22556 | ARTHRD ANT MIN DISCECTOMY INTERBODY THORACIC | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22558 | ARTHRODESIS ANTERIOR INTERBODY LUMBAR | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22586 | ARTHRODESIS PRESACRAL INTRBDY W INSTRUMENT L5-S1 | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22590 | ARTHRODESIS POSTERIOR CRANIOCERVICAL | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22595 | ARTHRODESIS POSTERIOR ATLAS-AXIS C1-C2 | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22600 | ARTHRODESIS PST PSTLAT CERVICAL BELW C2 SGM | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22610 | ARTHRODESIS POSTERIOR POSTEROLATERAL THORACIC | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22612 | ARTHRODESIS POSTERIOR POSTEROLATERAL LUMBAR | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22630 | ARTHRODESIS POSTERIOR INTERBODY LUMBAR | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22633 | ARTHDSIS POST POSTEROLATRL POSTINTERBODY LUMBAR | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22800 | ARTHRODESIS POSTERIOR SPINAL DFRM UP 6 VRT SEG | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22802 | ARTHRODESIS POSTERIOR SPINAL DFRM 7-12 VRT SEG | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22804 | ARTHRODESIS POSTERIOR SPINAL DFRM 13 OR GRT VRT SEG | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22808 | ARTHRODESIS ANTERIOR SPINAL DFRM 2-3 VRT SEG | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22810 | ARTHRODESIS ANTERIOR SPINAL DFRM 4-7 VRT SEG | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22812 | ARTHRODESIS ANTERIOR SPINAL DFRM 8 OR GRT VRT SEG | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |

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|---|---|---|---|---|---|---|
| 22818 | KYPHECTOMY SINGLE OR TWO SEGMENTS | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22819 | KYPHECTOMY 3 OR MORE SEGMENTS | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22849 | REINSERTION SPINAL FIXATION DEVICE | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22850 | REMOVAL POSTERIOR NONSEGMENTAL INSTRUMENTATION | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22852 | REMOVAL POSTERIOR SEGMENTAL INSTRUMENTATION | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22855 | REMOVAL ANTERIOR INSTRUMENTATION | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22856 | TOT DISC ARTHRP ART DISC ANT APPRO 1 NTRSPC CRV | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22857 | TOT DISC ARTHRP ART DISC ANT APPRO 1 NTRSPC LMBR | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22860 | TTL DSC ARTHRPLSTY (ARTFCL DISC), ANTRR APPRCH, INCLDNG DSCECTMY TO PRPRE INTRSPCE (OTHR THAN FOR DCMPRSSION); SCND INTRSPCE, LMBR | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 22861 | REVJ RPLCMT DISC ARTHROPLASTY ANT 1 NTRSPC CRV | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22862 | REVN RPLCMT DISC ARTHROPLASTY ANT 1 NTRSPC LMBR | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22864 | RMVL DISC ARTHROPLASTY ANT 1 INTERSPACE CERVICAL | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22865 | RMVL DISC ARTHROPLASTY ANT 1 INTERSPACE LUMBAR | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22867 | INSJ STABLJ DEV W DCMPRN LUMBAR SINGLE LEVEL | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22868 | INSJ STABLJ DEV W DCMPRN LUMBAR SECOND LEVEL | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22869 | INSJ STABLJ DEV W O DCMPRN LUMBAR SINGLE LEVEL | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 22870 | INSJ STABLJ DEV W O DCMPRN LUMBAR SECOND LEVEL | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 23410 | OPEN REPAIR OF ROTATOR CUFF ACUTE | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 23412 | OPEN REPAIR OF ROTATOR CUFF CHRONIC | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 23415 | CORACOACROMIAL LIGAMENT RELEAS W/WOACROMIOPLASTY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 23420 | RECONSTRUCTION ROTATOR CUFF AVULSION CHRONIC | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 23430 | TENODESIS LONG TENDON BICEPS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 23450 | CAPSULORRHAPHY ANTERIOR PUTTI-PLATT/MAGNUSON | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 23455 | CAPSULORRHAPHY ANTERIOR W/LABRAL REPAIR | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 23462 | CAPSULORRHAPHY ANTERIOR W/CORACOID PROCESS TR | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 23465 | CAPSULORRHAPHY GLENOHUMERAL JT PST W/WO BONE BLK | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 23466 | CAPSULORRHAPHY GLENOHUMRL JT MULTI-DIRIONAL INS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 23470 | ARTHROPLASTY GLENOHUMRL JT HEMIARTHROPLASTY | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 23472 | ARTHROPLASTY GLENOHUMERAL JOINT TOTAL SHOULDER | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 23473 | REVIS SHOULDER ARTHRPLSTY HUMERAL/GLENOID COMPNT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 23474 | REVIS SHOULDER ARTHRPLSTY HUMERAL AND GLENOID COMPNT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 23700 | MANJ W/ANES SHOULDER JOINT W/FIXATION APPARATUS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 25447 | ARTHRP INTERPOS INTERCARPAL METACARPAL JOINTS | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 27120 | ACETABULOPLASTY | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 27125 | HEMIARTHROPLASTY HIP PARTIAL | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 27130 | ARTHRP ACETBLR PROX FEM PROSTC AGRFT ALGRFT | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 27132 | CONV PREV HIP TOT HIP ARTHRP W WO AGRFT ALGRFT | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 27134 | REVJ TOT HIP ARTHRP BTH W WO AGRFT ALGRFT | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 27137 | REVN TOT HIP ARTHRP ACTBLR W WO AGRFT ALGRFT | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 27138 | REVJ TOT HIP ARTHRP FEM ONLY W WO ALGRFT | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 27332 | ARTHRT W/EXC SEMILUNAR CRTLG KNEE MEDIAL/LAT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 27333 | ARTHRT W/EXC SEMILUNAR CRTLG KNEE MEDIAL AND LAT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 27405 | RPR PRIMARY TORN LIGM AND /CAPSULE KNEE COLLATERAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 27407 | REPAIR PRIMARY TORN LIGM AND /CAPSULE KNEE CRUCIAT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 27409 | RPR 1 TORN LIGM AND /CAPSL KNE COLTRL AND CRUCIATE | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 27418 | ANTERIOR TIBIAL TUBERCLEPLASTY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 27420 | RCNSTN DISLOCATING PATELLA | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 27422 | RCNSTN DISLC PATELLA W/XTNSR RELIGNMT AND /MUSC RL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |

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| 27424 | RCNSTJ DISLC PATELLA W/PATELLECTOMY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 27427 | LIGAMENTOUS RECONSTRUCTION KNEE EXTRA-ARTICULAR | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 27428 | LIGAMENTOUS RECONSTRUCTION KNEE INTRA-ARTICULAR | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 27429 | LIGMOUS RCNSTJ AGMNTJ KNE INTRA-ARTICULAR XTR | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 27438 | ARTHROPLASTY PATELLA W PROSTHESIS | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 27440 | ARTHROPLASTY KNEE TIBIAL PLATEAU | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 27441 | ARTHRP KNEE TIBIAL PLATEAU DBRDMT AND PRTL SYNVCT | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 27442 | ARTHROPLASTY FEM CONDYLES TIBIAL PLATEAU KNEE | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 27443 | ARTHRP FEM CONDYLES TIBL PLATU KNE DBRDMT AND PRTL | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 27445 | ARTHROPLASTY KNEE HINGE PROSTHESIS | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 27446 | ARTHRP KNEE CONDYLE AND PLATEAU MEDIAL LAT CMPRT | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 27447 | ARTHRP KNE CONDYLE AND PLATU MEDIAL AND LAT COMPARTMENTS | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 27486 | REVJ TOTAL KNEE ARTHRP W WO ALGRFT 1 COMPONENT | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 27487 | REVJ TOT KNEE ARTHRP FEM AND ENTIRE TIBIAL COMPONE | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28005 | INCISION BONE CORTEX FOOT | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28035 | RELEASE TARSAL TUNNEL | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28060 | FASCIECTOMY PLANTAR FASCIA PARTIAL SPX | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28062 | FASCIOTOMY PLANTAR FASCIA RADICAL SPX | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28080 | EXCISION INTERDIGITAL MORTON NEUROMA SINGLE EACH | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28090 | EXC LESION TENDON SHEATH/CAPSULE W/SYNVCT FOOT | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28092 | EXC LESION TENDON SHEATH/CAPSULE W/SYNVCT TOE EA | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28104 | EXC/CURTG BONE CYST/B9 TUMORTARSAL/METATARSAL | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28108 | EXC CURTG CST B9 TUM PHALANGES FOOT | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28110 | OSTECTOMY PRTL 5TH METAR HEAD SPX | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28111 | OSTECTOMY COMPLETE 1ST METATARSAL HEAD | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28112 | OSTECTOMY COMPLETE OTHER METATARSAL HEAD 2 3 4 | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28113 | OSTECTOMY COMPLETE 5TH METATARSAL HEAD | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28118 | OSTECTOMY CALCANEUS | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28119 | OSTECTOMY CALCANEUS SPUR W WO PLNTAR FASCIAL RLS | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28120 | PARTIAL EXCISION BONE TALUS CALCANEUS | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28122 | PRTL EXC B1 TARSAL METAR B1 XCP TALUS CALCANEUS | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28124 | PARTIAL EXCISION BONE PHALANX TOE | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28200 | RPR TDN FLXR FOOT 1 2 W O FREE GRAFG EACH TENDON | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28202 | RPR TENDON FLXR FOOT SEC W FREE GRAFT EA TENDON | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28208 | REPAIR TENDON EXTENSOR FOOT 1 2 EACH TENDON | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28210 | RPR TENDON XTNSR FOOT SEC W FREE GRAFT EA TENDON | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28234 | TENOTOMY OPEN EXTENSOR FOOT TOE EACH TENDON | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28270 | CAPSUL MTTARPHLNGL JT W WO TENORRHAPHY EA JT SPX | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28285 | CORRECTION HAMMERTOE | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28286 | CORRECTION COCK-UP 5TH TOE W PLASTIC CLOSURE | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28288 | OSTC PRTL EXOSTC CONDYLC METAR HEAD | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28289 | HALLUX RIGIDUS W CHEILECTOMY 1ST MP JT W O IMPLT | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28291 | HALLUX RIGIDUS W CHEILECTOMY 1ST MP JT W IMPLT | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28292 | CORRJ HALLUX VALGUS W/SESMDC W/RESCJ PROX PHAL | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28295 | CORRJ HALLUX VALGUS W SESMDC W PROX METAR OSTEOT | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28296 | CORRJ HALLUX VALGUS W SESMDC W DIST METAR OSTEOT | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28297 | CORRJ HALLUX VALGUS W SESMDC W 1METAR MEDIAL CNF | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28298 | CORRJ HALLUX VALGUS W SESMDC W PROX PHLNX OSTEOT | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28299 | CORRJ HALLUX VALGUS W SESMDC W 2 OSTEOT | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |

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| 28300 | OSTEOTOMY CALCANEUS W WO INTERNAL FIXATION | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28304 | OSTEOTOMY TARSAL BONES OTH/THN CALCANEUS/TALUS | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28306 | OSTEOT W/WO LNGTH SHRT/CORRJ 1ST METAR | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28307 | OSTEOT W WO LNGTH SHRT CORRJ METAR XCP 1ST TOE | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28308 | OSTEOT W/WO LNGTH SHRT/CORRJ METAR XCP 1ST EA | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28309 | OSTEOT W WO LNGTH SHRT ANGULAR CORRJ METAR MLT | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28310 | OSTEOT SHRT CORRJ PROX PHALANX 1ST TOE | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28312 | OSTEOT SHRT CORRJ OTH PHALANGES ANY TOE | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28313 | RCNSTJ ANGULAR DFRM TOE SOFT TISS PX ONLY | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28315 | SESAMOIDECTOMY FIRST TOE SPX | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28320 | REPAIR NONUNION MALUNION TARSAL BONES | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28322 | RPR NON MALUNION METARSAL W WO BONE GRAFT | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28344 | RECONSTRUCTION TOE POLYDACTYLY | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28345 | RCNSTJ TOE SYNDACTYLY W WO SKIN GRAFT EACH WEB | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28705 | ARTHRODESIS PANTALAR | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28715 | ARTHRODESIS TRIPLE | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28725 | ARTHRODESIS SUBTALAR | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28730 | ARTHRD MIDTARSL TARSOMETATARSAL MULT TRANSVRS | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28735 | ARTHRD MIDTARSL TARS MLT TRANSVRS W OSTEOT | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28737 | ARTHRD W TDN LNGTH AND ADVMNT TARSL NVCLR-CUNEIFOR | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28740 | ARTHRODESIS MIDTARSOMETATARSAL SINGLE JOINT | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28750 | ARTHRODESIS GREAT TOE METATARSOPHALANGEAL JOINT | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28755 | ARTHRODESIS GREAT TOE INTERPHALANGEAL JOINT | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28760 | ARTHRD W XTNSR HALLUCIS LONGUS TR 1ST METAR NCK | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 28890 | ESWT HI NRG PHYS QHP W US GDN INVG PLNTAR FASCIA | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 29805 | ARTHROSCOPY SHOULDER DX W/WO SYNOVIAL BIOPSY SPX | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 29806 | ARTHROSCOPY SHOULDER SURGICAL CAPSULORRHAPHY | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 29807 | ARTHROSCOPY SHOULDER SURGICAL REPAIR SLAP LESION | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 29819 | ARTHROSCOPY SHOULDER SURGICAL REMOVAL LOOSE FB | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 29820 | ARTHROSCOPY SHOULDER SURG SYNOVECTOMY PARTIAL | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 29821 | ARTHROSCOPY SHOULDER SURG SYNOVECTOMY COMPLETE | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 29822 | ARTHROSCOPY SHOULDER SURG DEBRIDEMENT LIMITED | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 29823 | ARTHROSCOPY SHOULDER SURG DEBRIDEMENT EXTENSIVE | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 29824 | ARTHROSCOPY SHOULDER DISTAL CLAVICULECTOMY | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 29825 | ARTHROSCOPY SHOULDER AHESIOLYSIS W WO MANIPJ | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 29827 | ARTHROSCOPY SHOULDER ROTATOR CUFF REPAIR | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 29828 | ARTHROSCOPY SHOULDER BICEPS TENODESIS | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 29860 | ARTHROSCOPY HIP DIAGNOSTIC W/WO SYNOVIAL BYP SPX | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 29862 | ARTHRS HIP DEBRIDEMENT/SHAVING ARTICULAR CRTLG | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 29863 | ARTHROSCOPY HIP SURGICAL W/SYNOVECTOMY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 29866 | ARTHROSCOPY KNEE OSTEOCHONDRAL AGRFT MOSAICPLAST | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 29867 | ARTHROSCOPY KNEE OSTEOCHONDRAL ALLOGRAFT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 29868 | ARTHROSCOPY KNEE MENISCAL TRNSPLJ MED/LAT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 29870 | ARTHROSCOPY KNEE DIAGNOSTIC W/WO SYNOVIAL BX SPX | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 29873 | ARTHROSCOPY KNEE LATERAL RELEASE | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 29874 | ARTHROSCOPY KNEE REMOVAL LOOSE FOREIGN BODY | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 29875 | ARTHROSCOPY KNEE SYNOVECTOMY LIMITED SPX | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 29876 | ARTHROSCOPY KNEE SYNOVECTOMY 2 OR GRT COMPARTMENTS | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 29877 | ARTHRS KNEE DEBRIDEMENT SHAVING ARTCLR CRTLG | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 29879 | ARTHRS KNEE ABRASION ARTHRP MLT DRLG MICROFX | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |

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| 29880 | ARTHRS KNEE W MENISCECTOMY MED AND LAT W SHAVING | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 29881 | ARTHRS KNE SURG W MENISCECTOMY MED LAT W SHVG | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 29882 | ARTHROSCOPY KNEE W MENISCUS RPR MEDIAL LATERAL | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 29883 | ARTHROSCOPY KNEE W MENISCUS RPR MEDIAL AND LATERAL | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 29884 | ARTHROSCOPY KNEE W LYSIS ADHESIONS W WO MANJ SPX | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 29885 | ARTHRS KNEE DRILL OSTEOCHONDRITIS DISSECANS GRFG | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 29886 | ARTHRS KNEE DRILLING OSTEOCHOND DISSECANS LESION | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 29887 | ARTHRS KNEE DRLG OSTEOCHOND DISSECANS INT FIXJ | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 29888 | ARTHRS AIDED ANT CRUCIATE LIGM RPR AGMNTJ RCNSTJ | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 29889 | ARTHRS AIDED PST CRUCIATE LIGM RPR AGMNTJ RCNSTJ | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 29891 | ARTHRS ANKLE EXC OSTCHNDRL DFCT W DRLG DFCT | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 29892 | ARTHRS AID RPR LES TALAR DOME FX TIBL PLAFOND FX | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 29893 | ENDOSCOPIC PLANTAR FASCIOTOMY | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 29894 | ARTHROSCOPY ANKLE W REMOVAL LOOSE FOREIGN BODY | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 29895 | ARTHROSCOPY ANKLE SURGICAL SYNOVECTOMY PARTIAL | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 29897 | ARTHROSCOPY ANKLE SURGICAL DEBRIDEMENT LIMITED | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 29898 | ARTHROSCOPY ANKLE SURGICAL DEBRIDEMENT EXTENSIVE | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 29899 | ARTHROSCOPY ANKLE SURGICAL W ANKLE ARTHRODESIS | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 29914 | ARTHROSCOPY HIP W FEMOROPLASTY | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 29915 | ARTHROSCOPY HIP W ACETABULOPLASTY | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 29916 | ARTHROSCOPY HIP W LABRAL REPAIR | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 30465 | REPAIR NASAL VESTIBULAR STENOSIS | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 30469 | RPR OF NSL VLVE CLLPSE WTH LOW ENRGY, TMPRTURE-CNTRLLD (IE, RDFRQNCY) SBCTNEOUS/SUBMCSL RMDLNG | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 30520 | SEPTOPLASTY SUBMUCOUS RESECJ W WO CARTILAGE GRF | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 31253 | NASAL SINUS NDSC TOT W FRNT SINS EXPL TISS RMVL | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 31257 | NASAL SINUS NDSC TOTAL WITH SPHENOIDOTOMY | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 31259 | NASAL SINUS NDSC TOT W SPHENDT W SPHEN TISS RMVL | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 31295 | NASAL SINUS NDSC SURG W DILAT MAXILLARY SINUS | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 31296 | NASAL SINUS NDSC SURG W DILATION FRONTAL SINUS | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 31297 | NASAL SINUS NDSC SURG W DILATION SPHENOID SINUS | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 31298 | NASAL SINUS NDSC W FRONTAL AND SPHEN SINS DILATION | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 31660 | BRONCHOSCOPIC THERMOPLASTY ONE LOBE | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 31661 | BRONCHOSCOPIC THERMOPLASTY 2 OR GRT LOBES | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 32035 | THORACOSTOMY W/RIB RESECTION EMPYEMA | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32036 | THORACOSTOMY OPEN FLAP DRAINAGE EMPYEMA | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32096 | THORACTOMY W/DX BX LUNG INFILTRATE UNILATERAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32097 | THORACTOMY W/DX BX LUNG NODULE/MASS UNILATERAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32098 | THORACOTOMY W/BIOPSY OF PLEURA | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |

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| 32100 | THORACOTOMY WITH EXPLORATION | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32110 | THORCOM CTRL TRAUMTC HEMRRG AND /RPR LNG TEAR | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32120 | THORACOTOMY POSTOPERATIVE COMPLICATIONS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32124 | THORACOTOMY OPN INTRAPLEURAL PNEUMONOLYSIS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32140 | THORCOM W/REMOVAL OF CYST | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32141 | THORACOTOMY W/RESECTION BULLAE | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32150 | THORCOM W/RMVL INTRAPLEURAL FB/FIBRIN DEP | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32151 | THORCOM W/RMVL IPUL FB | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32160 | THORACOTOMY W/CARDIAC MASSAGE | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32200 | PNEUMONOSTOMY W/OPEN DRAINAGE ABSCESS/CYST | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32215 | PLEURAL SCARIFICATION REPEAT PNEUMOTHORAX | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32220 | DECORTICATION PULMONARY TOTAL SEPARATE PROCEDURE | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32225 | DECORTICATION PULMONARY PARTIAL SEPARATE PROC | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32440 | REMOVAL OF LUNG PNEUMONECTOMY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32442 | REMOVAL LUNG PNEUMONECTOMY RESXN SGMNT TRACHEA | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32445 | REMOVAL LUNG PNEUMONECTOMY EXTRAPLEURAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |

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| 32480 | RMVL LUNG OTHER THAN PNEUMONECTOMY 1 LOBE LOBECT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32482 | RMVL LUNG OTHER THAN PNEUMONECT 2 LOBES BILOBEC | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32484 | RMVL LUNG OTHER THAN PNEUMONECT 1 SEGMENTECTOMY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32486 | RMVL LUNG XCP TOT PNEUMONECTOMY SLEEVE LOBECTOMY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32488 | RMVL LUNG OTHER/THAN PNUMEC COMPLETION PNUMEC | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32491 | RMVL LUNG OTH/THN PNUMEC RESXN-PLCTJ EMPHY LUNG | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32501 | RESCJ AND BRONCHOPLASTY PFRMD TM LOBEC/SGMECTOMY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32503 | RESCJ APICAL LUNG TUMOR W/O CHEST WALL RCNSTJ | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32504 | RESCJ APICAL LUNG TUMOR W/CHEST WALL RCNSTJ | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32505 | THORACOTOMY W/THERAPEUTIC WEDGE RESEXN INITIAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32506 | THORACOTOMY W/THERAP WEDGE RESEXN ADDL IPSILATRL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32507 | THORACOTOMY W/DX WEDGE RESEXN AND ANTOM LUNG RESE | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32540 | EXTRAPLEURAL ENUCLEATION EMPYEMA EMPYEMECTOMY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32650 | THORACOSCOPY W/PLEURODESIS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32651 | THORACOSCOPY W/PARTIAL PULMONARY DECORTICATION | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32652 | THRSC TOT PULM DCRTCTJ INTRAPLEURAL PNEUMONOLSS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |

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| 32653 | THORACOSCOPY RMVL INTRAPLEURAL FB/FIBRIN DEPOSIT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32654 | THORACOSCOPY CONTROL TRAUMATIC HEMORRHAGE | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32655 | THORACOSCOPY W/RESECTION BULLAE W/WO PLEURAL PX | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32656 | THORACOSCOPY W/PARIETAL PLEURECTOMY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32658 | THORACOSCOPY W/RMVL CLOT/FB FROM PERICARDIAL SAC | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32659 | THRSC CRTJ PRCRD WINDOW/PRTL RESCJ PRCRD SAC | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32661 | THORACOSCOPY W/EXC PERICARDIAL CYST TUMOR/MASS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32662 | THORACOSCOPY W/EXC MEDIASTINAL CYST TUMOR/MASS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32663 | THORACOSCOPY W/LOBECTOMY SINGLE LOBE | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32664 | THORACOSCOPY W/THORACIC SYMPATHECTOMY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32665 | THORACOSCOPY W/ESOPHAGOMYOTOMY HELLER TYPE | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32666 | THORACOSCOPY W/THERA WEDGE RESEXN INITIAL UNILAT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32667 | THORACOSCOPY W/THERA WEDGE RESEXN ADDL IPSILATRL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32668 | THORACOSCOPY W/DX WEDGE RESEXN ANATO LUNG RESEXN | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32669 | THORACOSCOPY W/SEGMENTECTOMY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32670 | THORACOSCOPY W/BILOBECTOMY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |

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| 32671 | THORACOSCOPY W/PNEUMONECTOMY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32672 | THORACOSCOPY W/RESEXN-PLICAJ EMPHYSEMA LUNG UNIL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32673 | THORACOSCOPY RESEXN THYMUS UNI/BILATERAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32674 | THORCOSCPY W/MEDIASTINL AND REGIONL LYMPHDENECTOMY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32800 | REPAIR LUNG HERNIA THROUGH CHEST WALL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32810 | CLSR CH WALL FLWG OPN FLAP DRG EMPYEMA | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32815 | OPEN CLOSURE MAJOR BRONCHIAL FISTULA | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32820 | MAJOR RECONSTRUCTION CHEST WALL POSTTRAUMATIC | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32900 | RESECTION RIBS EXTRAPLEURAL ALL STAGES | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32905 | THORACOPLASTY SCHEDE TYPE/EXTRAPLEURAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32906 | THORACOP SCHEDE TYP/XTRPLEURAL CLSR BRNCPLR FSTL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32940 | PNEUMONOLYSIS XTRPRIOSTEAL W/FILLING/PACKING PX | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 32997 | TOTAL LUNG LAVAGE UNILATERAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33017 | PERQ PRCRD DRG 6YR PLUS W/O CONGENITAL CAR ANOMALY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33018 | PERQ PRCRD DRG 0-5YR/ANY AGE W/CGEN CAR ANOMALY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33019 | PERQ PERICARDIAL DRG W/INSJ NDWELLG CATH W/CT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |

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| 33020 | PERICARDIOTOMY REMOVAL CLOT/FOREIGN BODY PRIMARY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33025 | CRTJ PERICARDIAL WINDOW/PRTL RESECJ W/DRG/BX | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33030 | PRICARDIECTOMY STOT/COMPL W/O CARDPULM BYPASS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33031 | PRICARDIECTOMY STOT/COMPL W/CARDPULM BYPASS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33050 | RESECTION PERICARDIAL CYST/TUMOR | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33120 | EXC INTRACARDIAC TUMOR RESCJ CARDIOPULMONARY BYP | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33130 | RESECTION EXTERNAL CARDIAC TUMOR | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33140 | TRANSMYOCARDIAL LASER REVASCULAR THORACOTOMY SPX | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33141 | TRANSMYOCRD LASER REVSC PFRMD TM OTH OPN CAR PX | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33202 | INSERTION EPICARDIAL ELECTRODE OPEN | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33203 | INSERTION EPICARDIAL ELECTRODE ENDOSCOPIC | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33206 | INS NEW/RPLCMT PRM PACEMAKR W/TRANS ELTRD ATRIAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33207 | INS NEW/RPLC PRM PACEMAKER W/TRANSV ELTRD VENTR | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33208 | INS NEW RPLCMT PRM PM W TRANSV ELTRD ATRIAL & VENT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33210 | INSJ/RPLCMT TEMP TRANSVNS 1CHMBR ELTRD/PM CATH | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33211 | INSJ/RPLCMT TEMP TRANSVNS 2CHMBR PACG ELTRDS SPX | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |

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| 33212 | INS PM PLS GEN W/EXIST SINGLE LEAD | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33213 | INS PACEMAKER PULSE GEN ONLY W/EXIST DUAL LEADS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33214 | UPG PACEMAKER SYS CONVERT 1CHMBR SYS 2CHMBR SYS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33215 | RPSG PREV IMPLTED PM/DFB R ATR/R VENTR ELECTRODE | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33216 | INSJ 1 TRANSVNS ELTRD PERM PACEMAKER/IMPLTBL DFB | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33217 | INSJ 2 TRANSVNS ELTRD PERM PACEMAKER/IMPLTBL DFB | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33221 | INS PACEMAKER PULSE GEN ONLY W/EXIST MULT LEADS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33224 | INSJ ELTRD CAR VEN SYS ATTCH PREV PM/DFB PLS GEN | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33225 | INSJ ELTRD CAR VEN SYS TM INSJ DFB/PM PLS GEN | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33227 | REMVL PERM PM PLSE GEN W/REPL PLSE GEN SNGL LEAD | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33228 | REMVL PERM PM PLS GEN W/REPL PLSE GEN 2 LEAD SYS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33229 | REMVL PERM PM PLS GEN W/REPL PLSE GEN MULT LEAD | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33230 | INSJ IMPLNTBL DEFIB PULSE GEN W EXIST DUAL LEADS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33231 | INSJ IMPLNTBL DEFIB PULSE GEN W/EXIST MULTILEADS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33236 | RMVL PRM EPICAR PM AND ELTRDS THORCOM 1 LEAD SYS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33237 | RMVL PRM EPICAR PM AND ELTRDS THORCOM DUAL LEAD SY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |

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| 33238 | RMVL PRM TRANSVENOUS ELECTRODE THORACOTOMY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33240 | INSJ IMPLNTBL DEFIB PULSE GEN W/1 EXISTING LD | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33243 | RMVL 1/DUAL CHAMBER DEFIB ELECTRODE BY THORACOM | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33249 | INSJ/RPLCMT PERM DFB W/TRNSVNS LDS 1/DUAL CHMBR | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33250 | ABLATION ARRHYTHMOGENIC FOCI/PATHWAY W/O BYPASS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33251 | ABLATION ARRHYTHMOGENIC FOCI/PATHWAY W/BYPASS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33254 | ABLATION AND RECONSTRUCTION ATRIA LIMITED | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33255 | ABLATION AND RCNSTJ ATRIA EXTNSV W/O BYPASS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33256 | ABLATION AND RCNSTJ ATRIA EXTNSV W/BYPASS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33257 | ATRIA ABLATE AND RCNSTJ W/OTHER PROCEDURE LIMITE | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33258 | ATRIA ABLTJ AND RCNSTJ W/OTHER PX EXTENSIV W/O BYP | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33259 | ATRIA ABLTJ AND RCNSTJ W/OTHER PX EXTEN W/BYPASS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33261 | OPRATIVE ABLTJ VENTR ARRHYTHMOGENIC FOC W/BYPASS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33262 | RMVL IMPLTBL DFB PLSE GEN W/REPL PLSE GEN 1 LEAD | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33263 | RMVL IMPLTBL DFB PLSE GEN W/RPLCMT PLSE GEN 2 LD | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33264 | RMVL IMPLTBL DFB PLS GEN W/RPLCMT PLS GEN MLT LD | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |

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| 33265 | NDSC ABLATION AND RCNSTJ ATRIA LIMITED W/O BYPAS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33266 | NDSC ABLATION AND RCNSTJ ATRIA EXTEN W/O BYPASS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33267 | EXCLUSION LEFT ATRIAL APPENDAGE OPEN ANY METHOD | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33268 | EXCLUSION LAA OPEN TM STRNT/THRCM ANY METHOD | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33269 | EXCLUSION L ATR APPENDAGE THORACOSCOPIC ANY METH | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33270 | INS/RPLCMNT PERM SUBQ IMPLTBL DFB W/SUBQ ELTRD | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33274 | TCAT INSJ/RPL PERM LEADLESS PACEMAKER RV W/IMG | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33275 | TCAT REMOVAL PERM LEADLESS PACEMAKER R VENTR | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33285 | INSERTION SUBQ CARDIAC RHYTHM MONITOR W/PRGRMG | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33289 | TCAT IMPL WRLS P-ART PRS SNR L-T HEMODYN MNTR | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33300 | REPAIR CARDIAC WOUND W/O BYPASS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33305 | REPAIR CARDIAC WOUND W/CARDIOPULMONARY BYPASS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33310 | CARDIOT EXPL W/RMVL FB ATR/VENTR THRMB W/O BYP | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33315 | CARDIOT EXPL RMVL FB ATR/VENTR THRMB CARD BYP | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33320 | SUTR RPR AORTA/GRT VSL W/O SHUNT/CARD BYP | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33321 | SUTR RPR AORTA/GREAT VESSEL W/SHUNT BYPASS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |

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| 33322 | SUTURE REPAIR AORTA/GREAT VESSEL W/BYPASS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33330 | INSJ GRAFT AORTA/GREAT VESSEL W/O SHUNT/BYPASS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33335 | INSJ GRAFT AORTA/GREAT VESSEL W/BYPASS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33340 | PERQ CLSR TCAT L ATR APNDGE W/ENDOCARDIAL IMPLNT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33361 | REPLACE AORTIC VALVE PERQ FEMORAL ARTRY APPROACH | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33362 | REPLACE AORTIC VALVE OPENFEMORAL ARTERY APPROACH | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33363 | REPLACE AORTIC VALVE OPEN AXILLRY ARTRY APPROACH | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33364 | REPLACE AORTIC VALVE OPEN ILIAC ARTERY APPROACH | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33365 | REPLACE AORTIC VALVE OPEN TRANSAORTIC APPROACH | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33366 | TRANSCATHETER TRANSAPICAL REPLACEMT AORTIC VALVE | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33367 | REPLACE AORTIC VALVE W/BYP PRQ ART/VENOUS APPRCH | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33368 | REPLACE AORTIC VALVE W/BYP OPEN ART/VENOUS APRCH | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33369 | REPLACE AORTA VALVE W/BYP CNTRL ART/VENOUS APRCH | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33370 | TRANSCATHETER PLACEMENT AND SBSQ REMOVAL CEPD PERQ | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33390 | VALVULOPLASTY AORTIC VALVE OPEN CARD BYP SIMPLE | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33391 | VALVULOPLASTY AORTIC VALVE OPEN CARD BYP COMPLEX | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |

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| 33404 | CONSTRUCTION APICAL-AORTIC CONDUIT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33405 | RPLCMT PROST AORTIC VALVE OPEN XCP HOMOGRF/STENT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33406 | RPLCMT AORTIC VALVE OPN ALLOGRAFT VALVE FREEHAND | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33410 | RPLCMT AORTIC VALVE OPN W/STENTLESS TISSUE VALVE | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33411 | RPLCMT AORTIC VALVE ANNULUS ENLGMENT NONC SINUS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33412 | REPLACEMENT AORTIC VALVE KONNO PROCEDURE | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33413 | REPLACEMENT AORTIC AND PULMON VALVES ROSS PROCEDUR | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33414 | RPR VENTR O/F TRC OBSTRCJ PATCH ENLGMENT O/F TRC | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33415 | RESECTION/INCISION SUBVALVULAR TISSUE | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33416 | VENTRICULOMYOTOMY-MYECTOMY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33417 | AORTOPLASTY SUPRAVALVULAR STENOSIS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33418 | TCAT MITRAL VALVE REPAIR INITIAL PROSTHESIS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33419 | TCAT MITRAL VALVE REPAIR ADDL PROSTHESIS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33420 | VALVOTOMY MITRAL VALVE CLOSED HEART | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33422 | VALVOTOMY MITRAL VALVE OPEN HEART W/BYPASS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33425 | VALVULOPLASTY MITRAL VALVE W/CARDIAC BYPASS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |

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| 33426 | VLVP MITRAL VALVE W/CARD BYP W/PROSTC RING | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33427 | VLVP MITRAL VALVE W/BYPASS RAD RCNSTJ W/WO RING | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33430 | REPLACEMENT MITRAL VALVE W/CARDIOPULMONARY BYP | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33440 | RPLCMT AORTIC VALVE BY TLCJ AUTOL PULM VALVE | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33460 | VALVECTOMY TRICUSPID VALVE W/CARDIOPULMONARY BYP | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33463 | VALVULOPLASTY TRICUSPID VALVE W/O RING INSERTION | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33464 | VALVULOPLASTY TRICUSPID VALVE W/RING INSERTION | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33465 | REPLACEMENT TRICUSPID VALVE W/CARD BYPASS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33468 | TRICUSPID VALVE RPSG AND PLCTJ EBSTEIN ANOMALY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33474 | VALVOTOMY PULMONARY VALVE OPEN HEART W/BYPASS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33475 | REPLACEMENT PULMONARY VALVE | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33476 | R VENTRIC RESCJ INFUND STEN W/WO COMMISSUROTOMY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33477 | TCAT PULMONARY VALVE IMPLANTATION PRQ APPROACH | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33478 | OUTFLOW TRACT AGMNTJ W/WO COMMISSUR/INFUND RESCJ | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33496 | RPR NON-STRUCT PROSTC VALVE DYSFUNCTION W/BYPASS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33500 | RPR CORONARY AV/ARTERIOCAR CHMBR FSTL W/BYPASS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |

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| 33501 | RPR CORONARY AV/ARTERIOCAR CHMBR FSTL W/O BYPASS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33502 | RPR ANOM CORONARY ART PULM ART ORIGIN LIGATION | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33503 | RPR ANOM CORONARY ARTERY PULM ART ORIGIN GRAFT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33504 | RPR ANOM CORONARY ART PULM ART ORIGIN GRF W/BYP | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33505 | RPR ANOM CORON ART W/CONSTJ INTRAPULM ART TUNNEL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33506 | RPR ANOM CORONARY ART FROM PULM ART TO AORTA | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33507 | RPR ANOM AORTIC ORIGIN CORONARY ART UNROOF/TLCJ | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33508 | NDSC SURG W/VIDEO-ASSISTED HARVEST VEIN CABG | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33510 | CORONARY ARTERY BYPASS 1 CORONARY VENOUS GRAFT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33511 | CORONARY ARTERY BYPASS 2 CORONARY VENOUS GRAFTS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33512 | CORONARY ARTERY BYPASS 3 CORONARY VENOUS GRAFTS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33513 | CORONARY ARTERY BYPASS 4 CORONARY VENOUS GRAFTS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33514 | CORONARY ARTERY BYPASS 5 CORONARY VENOUS GRAFTS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33516 | CORONARY ARTERY BYPASS 6/ PLUS CORONARY VENOUS GRAFT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33517 | CORONARY ARTERY BYP W/VEIN AND ARTERY GRAFT 1 VEIN | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33518 | CORONARY ARTERY BYP W/VEIN AND ARTERY GRAFT 2 VEIN | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |

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| 33519 | CORONARY ARTERY BYP W/VEIN AND ARTERY GRAFT 3 VEIN | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33521 | CORONARY ARTERY BYP W/VEIN AND ARTERY GRAFT 4 VEIN | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33522 | CORONARY ARTERY BYP W/VEIN AND ARTERY GRAFT 5 VEIN | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33523 | CORONARY ARTERY BYP W/VEIN AND ARTERY GRAFT 6 VEIN | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33530 | ROPRTJ CAB/VALVE PX GT 1 MO AFTER ORIGINAL OPERJ | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33533 | CABG W/ARTERIAL GRAFT SINGLE ARTERIAL GRAFT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33534 | CABG W/ARTERIAL GRAFT TWO ARTERIAL GRAFTS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33535 | CABG W/ARTERIAL GRAFT THREE ARTERIAL GRAFTS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33536 | CABG W/ARTERIAL GRAFT FOUR OR GT ARTERIAL GRAFTS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33542 | MYOCARDIAL RESECTION | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33545 | RPR POSTINFRCJ VENTRICULAR SEPTAL DEFECT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33548 | SURG VENTRICULAR RSTRJ PX W/PROSTC PATCH PFRMD | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33572 | CORONARY ENDARTERCOMY OPEN ANY METHOD | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33600 | CLOSURE ATRIOVENTRICULAR VALVE SUTURE/PATCH | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33602 | CLOSURE SEMILUNAR VALVE AORTIC/PULM SUTURE/PATCH | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33606 | ANAST PULMONARY ART AORTA DAMUS-KAYE-STANSEL PX | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |

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| 33608 | RPR CAR ANOMAL XCP PULM ATRESIA VENTR SEPTL DFCT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33610 | RPR CAR ANOMAL SURG ENLGMENT VENTR SEPTL DFCT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33611 | RPR 2 OUTLET R VNTRC W/INTRAVENTR TUNNEL RPR | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33612 | RPR 2 OUTLET R VNTRC RPR R VENTR O/F TRC OBSTRCJ | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33615 | RPR CAR ANOMAL CLSR SEPTL DFCT SMPL FONTAN PX | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33617 | RPR COMPLEX CARDIAC ANOMALY MODIFIED FONTAN PX | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33619 | RPR 1 VNTRC W/O/F OBSTRCJ AND AORTIC ARCH HYPOPLAS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33620 | APPLICATION RIGHT AND LEFT PULMONARY ARTERY BAND | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33621 | TRANSTHORACIC CATHETER INSERTION FOR STENT PLMT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33622 | RECONSTRUCTION COMPLEX CARDIAC ANOMALY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33641 | RPR ATRIAL SEPTAL DFCT SECUNDUM W/BYP W/WO PATCH | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33645 | DIR/PTCH CLS SINUS VENOSUS W/WO ANOM PUL VEN DRG | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33647 | RPR ATRIAL AND VENTRIC SEPTAL DFCT DIR/PATCH CLS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33660 | RPR INCPLT/PRTL AV CANAL W/WO AV VALVE RPR | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33665 | RPR INTRM/TRANSJ AV CANAL W/WO AV VALVE RPR | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33670 | RPR COMPL AV CANAL W/WO PROSTC VALVE | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |

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| 33675 | CLOSURE MULTIPLE VENTRICULAR SEPTAL DEFECTS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33676 | CLOSURE MULTIPLE VSD W/RESECTION | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33677 | CLOSURE MULTIPLE VSD W/REMOVAL ARTERY BAND | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33681 | CLSR 1 VENTRICULAR SEPTAL DEFECT W/WO PATCH | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33684 | CLSR V-SEPTL DFCT W/PULM VLVT/INFUND RESCJ | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33688 | CLSR V-SEPTAL DFCT W/RMVL P-ART BAND W/WO GUSSET | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33690 | BANDING PULMONARY ARTERY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33692 | COMPL RPR TETRALOGY FALLOT W/O PULM ATRESIA | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33694 | COMPL RPR T-FALLOT W/O PULM ATRESIA TANULR PATCH | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33697 | COMPL RPR T-FALLOT W/PULM ATRESIA | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33702 | RPR SINUS VALSALVA FISTULA | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33710 | RPR SINUS VALSALVA FISTULA W/RPR V-SEPTAL DEFECT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33720 | RPR SINUS VALSALVA ANEURYSM | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33724 | REPAIR ISOLATED PARTIAL PULM VENOUS RETURN | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33726 | REPAIR PULMONARY VENOUS STENOSIS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33730 | COMPLETE RPR ANOMALOUS PULMONARY VENOUS RETURN | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |

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| 33732 | RPR COR TRIATM/SUPVALVR RING RESCJ L ATRIAL MEMB | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33735 | ATRIAL SEPTECTOMY/SEPTOSTOMY CLOSED HEART | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33736 | ATRIAL SEPTECTOMY/SEPTOSTOMY OPEN HEART W/BYPASS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33741 | TRNSCTHTR ATRIAL SPTSTMY FOR CONGENITAL CRDC ANMLS TO CREATE EFFCTV ATRIAL FLOW, INCLUDING ALL IMAGING GUIDANCE BY THE PROCEDURALIST, WHEN PERFORMED, ANY METHOD | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33745 | TIS CREATION BY STENT PLACEMENT FOR CONGENITAL CARDIAC ANOMALIES TO ESTABLISH EFFECTIVE INTRACARDIAC FLOW, INCLUDING ALL IMAGING GUIDANCE BY THE PROCEDURALIST, WHEN PERFORMED, LEFT AND RIGHT HEART DIAGNOSTIC CARDIAC CATH 1ST SHUNT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33746 | TIS CREATION BY STENT PLACEMENT FOR CONGENITAL CARDIAC ANOMALIES TO ESTABLISH EFFECTIVE INTRACARDIAC FLOW, INCLUDING ALL IMAGING GUIDANCE BY THE PROCEDURALIST, WHEN PERFORMED, LEFT AND RIGHT HEART DIAGNOSTIC CARDIAC CATH EA ADDL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33750 | SHUNT SUBCLAVIAN PULMONARY ARTERY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33755 | SHUNT ASCENDING AORTA PULMONARY ARTERY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33762 | SHUNT DESCENDING AORTA PULMONARY ARTERY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33764 | SHUNT CENTRAL W/PROSTHETIC GRAFT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33766 | SHUNT SUPERIOR VENA CAVA PULMONARY ART 1 LUNG | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33767 | SHUNT SUPERIOR VENA CAVA PULM ARTERY BOTH LUNGS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33768 | ANASTOMOSIS CAVOPULMARY 2ND SUPRIOR VENA CAVA | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33770 | RPR TRPOS GREAT VSLS W/O ENLGMNT V-SEPTL DFCT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33771 | RPR TRPOS GREAT VSLS W/ENLGMNT V-SEPTL DFCT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |

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| 33774 | RPR TRPOS GREAT VSLS ATRIAL BAFFLE PX W/BYPASS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33775 | RPR TRPOS GREAT VSLS ATR BAFFLE W/RMVL PULM BAND | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33776 | RPR TRPOS GRT VSL ATR BAFFLE W/CLSR V-SEPTL DFCT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33777 | RPR TRPOS GRT VSL ATR BAFFLE W/BYP SBPULM OBSTRC | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33778 | RPR TRPOS GRT VESSEL AORTIC PULMONARY ART RCNSTJ | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33779 | RPR TGV AORTIC PULM ART RCNSTJ W/RMVL PULM BAND | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33780 | RPR TGV AORTIC P-ART RCNSTJ W/CLSR V-SEPTL DFCT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33781 | RPR TGV AORTIC P-ART RCNSTJ RPR SBPULMC OBSTRCJ | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33782 | A-ROOT TLCJ VSD PULM STNS RPR W/O C OST RIMPLTJ | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33783 | A-ROOT TLCJ VSD PULM STNS RPR W/RIMPLTJ C OSTIA | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33786 | TOTAL REPAIR TRUNCUS ARTERIOSUS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33788 | REIMPLANTATION ANOMALOUS PULMONARY ARTERY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33800 | AORTIC SUSPENSION TRACHEAL DECOMPRESSION SPX | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33802 | DIVISION ABERRANT VESSEL VASCULAR RING | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33803 | DIVISION ABERRANT VESSEL W/REANASTOMOSIS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33814 | OBLTRJ AORTOPULMONARY SEPTAL DEFECT W/BYPASS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |

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| 33820 | REPAIR PATENT DUCTUS ARTERIOSUS LIGATION | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33824 | RPR PATENT DUXUS ARTERIOSUS DIV 18 YR AND OLDER | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33840 | EXC COARCJ AORTA W/WO PDA W/DIRECT ANASTOMOSIS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33845 | EXCISION COARCTATION AORTA W/WO PDA W/GRAFT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33851 | EXC COARCJ AORTA W/L SUBCLAV ART/PROSTC GUSSET | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33852 | RPR HYPOPLSTC A-ARCH W/AGRFT/PROSTC W/O BYPASS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33853 | RPR HYPOPLSTC A-ARCH W/AGRFT/PROSTC W/BYPASS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33863 | AS-AORT GRF W/CARD BYP AND AORTIC ROOT RPLCMT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33864 | ASCENDING AORTA GRF VALVE SPARE ROOT REMODEL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33866 | AORTIC HEMIARCH GRAFT W/ISOL AND CTRL ARCH VESSELS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33875 | DESCENDING THORACIC AORTA GRAFT W/WO BYPASS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33877 | RPR THORACOABDOMINAL AORTIC ANEURYS W/WO BYPASS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33880 | EVASC RPR DTA COVERAGE ART ORIGIN 1ST ENDOPROSTH | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33881 | EVASC RPR DTA EXP COVERAGE W/O ART ORIGIN | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33883 | PLMT PROX XTN PROSTH EVASC RPR DTA 1ST XTN | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33884 | PLMT PROX XTN PROSTH EVASC RPR DTA EA PROX XTN | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |

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| 33886 | PLMT DSTL XTN PROSTH DLYD AFTER EVASC RPR DTA | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33889 | OPN SUBCLA CRTD ART TRPOS NCK INC ULAT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33891 | BYP GRF W/DESCENDING THORACIC AORTA RPR NECK INC | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33900 | PERQ P-ART REVSC ST 1ST NML NATIVE CONNJ UNI | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33901 | PERQ P-ART REVSC ST 1ST NML NATIVE CONNJ BI | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33902 | PERQ P-ART REVSC ST 1ST ABNOR CONNJ UNILATERAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33903 | PERQ P-ART REVSC ST 1ST ABNORMAL CONNJ BILATERAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33910 | PULMONARY ARTERY EMBOLECTOMY W/CARD BYPASS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33915 | PULMONARY ARTERY EMBOLECTOMY W/O CARD BYPASS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33916 | PULMONARY ENDARTERCOMY W/WO EMBOLECTOMY W/BYPASS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33917 | RPR PULMONARY ART STENOSIS RCNSTJ W/PATCH/GRAFT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33920 | RPR PULMONARY ATRESIA W/CONSTJ/RPLCMT CONDUIT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33922 | TRANSECTION PULMONARY ARTERY W/CARD BYPASS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33924 | LIG AND TKDN SYSIC-TO-PULM ART SHUNT W/CGEN HEART | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33925 | RPR P-ART ARBORIZJ ANOMAL UNIFCLIZJ W/O BYPASS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33926 | RPR P-ART ARBORIZJ ANOMAL UNIFCLIZJ W/BYPASS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 33975 | INSJ VENTRIC ASSIST DEV XTRCORP SINGLE VENTRICLE | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 33976 | INSJ VENTRIC ASSIST DEV XTRCORP BIVENTRICULAR | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |

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| 33979 | INSJ VENTR ASSIST DEV IMPLTABLE ICORP 1 VNTRC | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 34001 | EMBLC/THRMBC CATH CRTD SUBCLA/INNOMINATE ART | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 34051 | EMBLC/THRMBC INNOMINATE SUBCLAVIAN ARTERY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 34151 | EMBLC/THRMBC RNL CELIAC MESENTRY AORTO-ILIAC ART | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 34401 | THRMBC DIR/W/CATH VENA CAVA ILIAC VEIN ABDL INC | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 34451 | THRMBC DIR/W/CATH V/C ILIAC FEMPOP VEIN ABDL & LEG | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 34502 | RECONSTRUCTION VENA CAVA ANY METHOD | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 34701 | EVASC RPR DPLMNT AORTO-AORTIC NDGFT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 34702 | EVASC RPR DPLMNT AORTO-AORTIC NDGFT RPT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 34703 | VASC RPR DPLMNT AORTO-UN-ILIAC NDGFT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 34704 | EVASC RPR DPLMNT AORTO-UN-ILIAC NDGFT RPT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 34705 | EVASC RPR DPLMNT AORTO-BI-ILIAC NDGFT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 34706 | EVASC RPR DPLMNT AORTO-BI-ILIAC NDGFT RPT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 34707 | EVASC RPR DPLMNT ILIO-ILIAC NDGFT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 34708 | EVASC RPR DPLMNT ILIO-ILIAC NDGFT RPT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 34709 | PLACEMENT XTN PROSTH FOR ENDOVASCULAR RPR | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 34710 | THRMBC DIR/W/CATH AXILL AND SUBCLAVIAN VEIN ARM IN | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |

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| 34711 | DLYD PLACEMENT XTN PROSTH FOR EVASC RPR EA ADDL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 34712 | TRANSCATHETER DLVR ENHNCD FIXATION DEVICES RS AND I | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 34717 | EVASC RPR ILIAC ART TM OF A-ILIAC ART NDGFT UNI | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 34718 | EVASC RPR DPLMNT AORTO-UN-ILIAC NDGFT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 34808 | EVASC PLACEMENT ILIAC ARTERY OCCLUSION DEVICE | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 34812 | OPN FEM ART EXPOS DLVR EVASC PROSTH UNI | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 34813 | PLMT FEM-FEM PROSTC GRF EVASC AORTIC ARYSM RPR | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 34820 | OPN ILIAC ART EXPOS PROSTH/ILIAC OCCLS EVASC UNI | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 34830 | OPN RPR ARYSM RPR ARTL TRAUMA TUBE PROSTH | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 34831 | OPN RPR ARYSM RPR ARTL TRMA AORTOBIILIAC PROSTH | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 34832 | DLYD PLACEMENT XTN PROSTH FOR EVASC RPR 1ST VSL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 34833 | OPN ILIAC ART EXPOS CRTJ PROSTH EST CARD BYP | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 34834 | OPN BRACHIAL ARTERY EXPOS DLVR EVASC PROSTH UNI | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 34839 | PLNNING PT SPEC FENEST VISCERAL AORTIC GRAFT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 34841 | ENDOVASC VISCER AORTA REPAIR FENEST 1 ENDOGRAFT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 34842 | ENDOVASC VISCER AORTA REPAIR FENEST 2 ENDOGRAFT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |

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| 34843 | ENDOVASC VISCER AORTA REPAIR FENEST 3 ENDOGRAFT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 34844 | ENDOVASC VISCER AORTA REPR FENEST 4 PLUS ENDOGRAFT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 34845 | EVASC RPR ILIAC ART N/A A-ILIAC ART NDGFT UNI | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 34846 | VISCER AND INFRARENAL ABDOM AORTA 2 PROSTHESIS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 34847 | VISCER AND INFRARENAL ABDOM AORTA 3 PROSTHESIS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 34848 | VISCER AND INFRARENAL ABDOM AORTA 4 PLUS PROSTHESIS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35001 | DIR RPR ANEURYSM CAROTID-SUBCLAVIAN ARTERY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35002 | DIR RPR RUPTD ANEURYSM CAROTID-SUBCLAVIAN ARTERY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35005 | DIR RPR ANEURYSM VERTEBRAL ARTERY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35013 | DIR RPR RUPTD ANEURYSM AXIL-BRACHIAL ARM INCIS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35021 | DIR RPR ANEURYSM INNOMINATE/SUBCLAVIAN ARTERY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35022 | DIR RPR RUPTD ANEURYSM INNOMINATE/SUBCLAVIAN | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35081 | DIR RPR ANEURYSM ABDOMINAL AORTA | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35082 | DIR RPR RUPTD ANEURYSM ABDOMINAL AORTA | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35091 | DIR RPR ANEURYSM ABDOM AORTA W/VISCERAL VESSELS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35092 | VISCER AND INFRARENAL ABDOM AORTA 1 PROSTHESIS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |

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| 35102 | DIR RPR ANEURYSM ABDOM AORTA W/ILIAC VESSELS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35103 | DIR RPR RUPTD ANEURYSM ABDOM AORTA W/ILIAC VSLS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35111 | DIR RPR ANEURYSM SPLENIC ARTERY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35112 | DIR RPR RUPTD ANEURYSM SPLENIC ARTERY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35121 | DIR RPR ANEURYSM HEPATIC/CELIAC/RENAL/MESENTERIC | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35122 | DIR RPR RUPTD ANEURSM HEPATIC/CELIAC/RENAL/MESEN | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35131 | DIR RPR ANEURYSM AXIL-BRACHIAL ARM INCISION | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35132 | DIR RPR RUPTD ANEURYSM AND GRAFT ILIAC ARTERY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35141 | DIR RPR ANEURYSM AND GRAFT COMMON FEMORAL ARTERY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35142 | DIR RPR RUPTD ANEURYSM AND GRF COMMON FEMORAL ART | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35151 | DIR RPR RUPTD ANEURYSM RADIAL/ULNAR ARTERY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35152 | DIR RPR RUPTD ANEURYSM AND GRF POPLITEAL ARTERY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35182 | RPR CONGENITAL AV FISTULA THORAX AND ABDOMEN | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35189 | RPR/TRAUMATIC AV FISTULA THORAX & ABDOMEN | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35211 | DIR RPR ANEURYSM AND GRAFT ILIAC ARTERY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35216 | RPR BLOOD VESSEL DIRECT INTRATHORACIC W/O BYPASS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |

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| 35221 | RPR BLOOD VESSEL DIRECT INTRA-ABDOMINAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35241 | RPR BLOOD VESSEL VEIN GRAFT INTRATHORACIC W/BYP | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35246 | RPR BLOOD VESSEL VEIN GRF INTRATHORACIC W/O BYP | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35251 | REPAIR BLOOD VESSEL VEIN GRAFT INTRA-ABDOMINAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35271 | RPR BLOOD VSL GRF OTH/THN VEIN INTRATHRC W/BYP | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35276 | RPR BLOOD VSL GRF OTH/THN VEIN INTRATHRC W/O BYP | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35281 | RPR BLVSL W/GRFT OTHER/THAN VEIN INTRA-ABDOMINAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35301 | TEAEC W/PATCH GRF CAROTID VERTB SUBCLAV NECK INC | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35302 | TEAEC W/GRAFT SUPERFICIAL FEMORAL ARTERY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35303 | TEAEC W/GRAFT POPLITEAL ARTERY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35304 | TEAEC W/GRAFT TIBIOPERONEAL TRUNK ARTERY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35305 | TEAEC W/GRAFT TIBIAL/PERONEAL ART 1ST VESSEL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35306 | TEAEC W/GRAFT EA ADDL TIBIAL/PERONEAL ART | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35311 | TEAEC W/WO PATCH GRF SUBCLAV INNOM THORACIC INC | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35331 | TEAEC W/WO PATCH GRAFT ABDOMINAL AORTA | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35341 | TEAEC W/WO PATCH GRAFT MESENTERIC CELIAC/RENAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |

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| 35351 | TEAEC W/WO PATCH GRAFT ILIAC | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35355 | TEAEC W/WO PATCH GRAFT ILIOFEMORAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35361 | TEAEC W/WO PATCH GRAFT COMBINED AORTOILIAC | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35363 | TEAEC W/WO PATCH GRAFT COMBINED AORTOILIOFEMORAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35371 | TEAEC W/WO PATCH GRAFT COMMON FEMORAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35372 | TEAEC W/WO PATCH GRAFT DEEP PROFUNDA FEMORAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35390 | ROPRTJ CRTD TEAEC GT 1 MO AFTER ORIGINAL OPRATIO | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35400 | ANGIOSCOPY NON-CORONARY VESSEL/GRAFTS THER IVNTJ | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35500 | HARVEST UXTR VEIN 1 SGM LOWER EXTREMITY/CABG PX | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35501 | BYPASS W/VEIN COMMON-IPSILATERAL CAROTID | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35506 | BYPASS W/VEIN CAROTID-SUBCLV/SUBCLAVIAN CAROTID | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35508 | BYPASS W/VEIN CAROTID-VERTEBRAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35509 | BYPASS W/VEIN CAROTID-CONTRALATERAL CAROTID | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35510 | BYPASS W/VEIN CAROTID-BRACHIAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35511 | BYPASS W/VEIN SUBCLAVIAN-SUBCLAVIAN | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35512 | BYPASS W/VEIN SUBCLAVIAN-BRACHIAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |

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| 35515 | BYPASS W/VEIN SUBCLAVIAN-VERTEBRAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35516 | BYPASS W/VEIN SUBCLAVIAN-AXILLARY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35518 | BYPASS W/VEIN AXILLARY-AXILLARY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35521 | BYPASS W/VEIN AXILLARY-FEMORAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35522 | BYPASS W/VEIN AXILLARY-BRACHIAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35523 | BYPASS W/VEIN BRACHIAL-ULNAR/-RADIAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35525 | BYPASS W/VEIN BRACHIAL-BRACHIAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35526 | BYPASS W/VEIN AORTOSUBCLAV/CAROTID/INNOMINATE | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35531 | BYPASS W/VEIN AORTOCELIAC/AORTOMESENTERIC | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35533 | BYPASS W/VEIN AXILLARY-FEMORAL-FEMORAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35535 | BYPASS W/VEIN HEPATORENAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35536 | BYPASS W/VEIN SPLENORENAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35537 | BYPASS W/VEIN AORTOILIAC | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35538 | BYPASS W/VEIN AORTOBI-ILIAC | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35539 | BYPASS W/VEIN AORTOFEMORAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35540 | BYPASS W/VEIN AORTOBIFEMORAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |

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| 35556 | BYPASS W/VEIN FEMORAL-POPLITEAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35558 | BYPASS W/VEIN FEMORAL-FEMORAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35560 | BYPASS W/VEIN AORTORENAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35563 | BYPASS W/VEIN ILIOILIAC | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35565 | BYPASS W/VEIN ILIOFEMORAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35566 | BYP FEM-ANT TIBL PST TIBL PRONEAL ART/OTH DSTL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35570 | BYP TIBL-TIBL/PRONEAL-TIBL/TIBL/PRONEAL TRK-TIBL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35571 | BYP W/VEIN POP-TIBL-PRONEAL ART/OTH DSTL VSL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35572 | HARVEST FEMPOP VEIN 1 SGM VASC RCNSTJ PX | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35583 | IN-SITU VEIN BYPASS FEMORAL-POPLITEAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35585 | IN-SITU FEM-ANT TIBL PST TIBL/PRONEAL ART | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35587 | IN-SITU VEIN BYP POP-TIBL PRONEAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35600 | OPEN HARVEST UPPER EXTREMITY ART 1 SEGMENT CAB | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35601 | BYP OTH/THN VEIN COMMON-IPSILATERAL CAROTID | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35606 | BYP OTH/THN VEIN CAROTID-SUBCLAVIAN | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35612 | BYP OTH/THN VEIN SUBCLAVIAN-SUBCLAVIAN | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |

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| 35616 | BYP OTH/THN VEIN SUBCLAVIAN-AXILLARY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35621 | BYP OTH/THN VEIN AXILLARY-FEMORAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35623 | BYP OTH/THN VEIN AXILLARY-POPLITEAL/-TIBIAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35626 | BYPASS NOT VEIN AORTOSUBCLA/CAROTID/INNOMINATE | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35631 | BYP OTH/THN VEIN AORTOCELIAC AORTOMSN AORTORNL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35632 | BYPASS GRAFT W/OTHER THAN VEIN ILIO-CELIAC | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35633 | BYPASS GRAFT W/OTHER THAN VEIN ILIO-MESENTERIC | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35634 | BYPASS GRAFT W/OTHER THAN VEIN ILIORENAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35636 | BYP OTH/THN VEIN SPLENORENAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35637 | BYP OTH/THN VEIN AORTOILIAC | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35638 | BYP OTH/THN VEIN AORTOBI-ILIAC | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35642 | BYP OTH/THN VEIN CAROTID-VERTEBRAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35645 | BYP OTH/THN VEIN SUBCLAVIAN-VERTEBRAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35646 | BYP OTH/THN VEIN AORTOBIFEMORAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35647 | BYP OTH/THN VEIN AORTOFEMORAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35650 | BYP OTH/THN VEIN AXILLARY-AXILLARY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |

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| 35654 | BYP OTH/THN VEIN AXILLARY-FEMORAL-FEMORAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35656 | BYP OTH/THN VEIN FEMORAL-POPLITEAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35661 | BYP OTH/THN VEIN FEMORAL-FEMORAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35663 | BYP OTH/THN VEIN ILIOILIAC | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35665 | BYP OTH/THN VEIN ILIOFEMORAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35666 | BYP OTH/THN VEIN FEM-ANT TIBL PST TIBL/PRONEAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35671 | BYP OTH/THN VEIN POPLITEAL-TIBIAL/-PERONEAL ART | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35681 | BYPASS COMPOSITE GRAFT PROSTHETIC AND VEIN | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35682 | BYP AUTOG COMPOSIT 2 SEG VEINS FROM 2 LOCATIONS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35683 | BYP AUTOG COMPOSIT 3 OR GT SEG FROM 2 OR GT LOCATION | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35685 | PLMT VEIN PATCH/CUFF DSTL ANAST BYP CONDUIT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35686 | CRTJ DSTL ARVEN FSTL LXTR BYP SURG NON-HEMO | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35691 | TRPOS AND /RIMPLTJ VERTEBRAL CAROTID ART | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35693 | TRPOS AND /RIMPLTJ VERTEBRAL SUBCLAVIAN ART | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35694 | TRPOS AND /RIMPLTJ SUBCLAVIAN CAROTID ART | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35695 | TRPOS AND /RIMPLTJ CAROTID SUBCLAVIAN ART | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |

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| 35697 | RIMPLTJ VISC ART INFRARNL AORTIC PROSTH EA ART | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35700 | ROPRTJ GT 1 MO AFTER ORIGINAL OPRATION | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35701 | EXPLORATION N/FLWD SURG NECK ARTERY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35702 | EXPLORATION N/FLWD SURG UPPER EXTREMITY ARTERY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35703 | EXPLORATION N/FLWD SURG LOWER EXTREMITY ARTERY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35800 | EXPL PO HEMRRG THROMBOSIS/INFCTJ NCK | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35820 | EXPL PO HEMRRG THROMBOSIS/INFCTJ CH | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35840 | EXPL PO HEMRRG THROMBOSIS/INFCTJ ABD | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35870 | RPR GRF-ENTERIC FSTL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35901 | EXCISION INFECTED NECK GRAFT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35905 | EXCISION INFECTED GRAFT THORAX | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 35907 | EXCISION INFECTED GRAFT ABDOMEN | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 36465 | NJX NONCMPND SCLEROSANT SINGLE INCMPTNT VEIN | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 36466 | NJX NONCMPND SCLEROSANT MULTIPLE INCMPTNT VEINS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 36468 | INJECTIONS SCLEROSANT FOR SPIDER VEINS LIM TRNK | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 36470 | INJXN SCLRSNT SINGLE INCMPTNT VEIN | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 36471 | INJXN SCLRSNT MLTPLE INCMPTNT VEINS, SAME LEG | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |

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| 36473 | ENDOVEN ABLTJ INCMPTNT VEIN MCHNCHEM 1ST VEIN | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 36474 | ENDOVEN ABLTJ INCMPTNT VEIN MCHNCHEM SBSQ VEINS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 36475 | ENDOVEN ABLTJ INCMPTNT VEIN XTR RF 1ST VEIN | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 36476 | ENDOVEN ABLTJ INCMPTNT VEIN XTR RF 2ND PLUS VEINS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 36478 | ENDOVEN ABLTJ INCMPTNT VEIN XTR LASER 1ST VEIN | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 36479 | ENDOVEN ABLTJ INCMPTNT VEIN XTR LASER 2ND PLUS VEINS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 36482 | ENDOVEN ABLTI THER CHEM ADHESIVE 1ST VEIN | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 36483 | ENDOVEN ABLTI THER CHEM ADHESIVE SBSQ VEIN | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 37191 | INSRTN INTRVAS VC FLTR W/ VAS ACS VSL SELXN RS AND I | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 37215 | TCAT IV STENT CRV CRTD ART EMBOLIC PROTECJ | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 37216 | TCAT IV STENT CRV CRTD ART W/O EMBOLIC PROTECJ | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 37217 | TCATH STENT PLACEMT RETROGRAD CAROTID/INNOMINATE | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 37218 | TCATH STENT PLACEMT ANTEGRADE CAROTID/INNOMINATE | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 37220 | REVASCULARIZATION ILIAC ARTERY ANGIOP 1ST VSL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 37221 | REVSC OPN/PRQ ILIAC ART W/STNT PLMT & ANGIOPLSTY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 37224 | REVSC OPN/PRG FEM/POP W/ANGIOPLASTY UNI | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |

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| 37225 | REVSC OPN/PRQ FEM/POP W/ATHRC/ANGIOP SM VSL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 37226 | REVSC OPN/PRQ FEM/POP W/STNT/ANGIOP SM VSL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 37227 | REVSC OPN/PRQ FEM/POP W/STNT/ATHRC/ANGIOP SM VSL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 37228 | REVSC OPN/PRQ TIB/PERO W/ANGIOPLASTY UNI | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 37229 | REVSC OPN/PRQ TIB/PERO W/ATHRC/ANGIOP SM VSL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 37230 | REVSC OPN/PRQ TIB/PERO W/STNT/ANGIOP SM VSL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 37231 | REVSC OPN/PRQ TIB/PERO W/STNT/ATHR/ANGIOP SM VSL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 37243 | VASCULAR EMBOLIZE/OCCLUDE ORGAN TUMOR INFARCT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 37500 | VASC ENDOSCOPY SURG W/LIG PERFORATOR VEINS SPX | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 37618 | LIGATION MAJOR ARTERY EXTREMITY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 37660 | LIGATION OF COMMON ILIAC VEIN | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 37700 | LIGTN &DIVSN LONG SAPH VEIN SAPHFEM JUNCT/ DSTAL INTERRUPN | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 37718 | LIGTN DIVSN AND STRIPPING SHORT SAPHENOUS VEIN | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 37722 | LIGTN DIVSN AND STRIPNG LONG SAPH SAPHFEM JUNCT KNE BELW | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 37735 | LIGTN AND DIVN RDCL STRIPNG LONG SHORT SAPHENOUS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 37760 | LIG PRFRATR VEIN SUBFSCAL RAD INCL SKN GRF 1 LEG | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |

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| 37761 | LIG PRFRATR VEIN SUBFSCAL OPEN INCL US GID 1 LEG | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 37765 | STAB PHLEBT VARICOSE VEINS 1 XTR 10-20 STAB INCS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 37766 | STAB PHLEBT VARICOSE VEINS 1 XTR > 20 INCS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 37780 | LIGTN & DIVSN SHORT SAPH VEIN SAPHENPOPLTL JUNCT SPX | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 37785 | LIGTN DIVSN AND EXCSN VARICOSE VEIN CLUSTER 1 LEG | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 38746 | THORCOM THRC W/MEDSTNL AND REGIONAL LMPHADEC | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 39000 | MEDIAST W/EXPL DRG RMVL FB/BX CRV APPR | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 39010 | MEDIAST W/EXPL DRG RMVL FB/BX TTHRC APPR | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 39200 | RESECTION OF MEDIASTINAL CYST | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 39220 | RESECTION MEDIASTINAL TUMOR | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 42975 | DISE DYN EVAL SLEEP DISORDERED BREATHING FLX DX | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 43291 | ESPHGGSTRDUDNSCPY, FLXIBLE, TRNSORAL; WITH RMVL OF INTRAGASTRIC BARIATRIC BALLON(S) | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 43644 | LAPS GSTR RSTCV PX W BYP ROUX-EN-Y LIMB UNDER 150 CM | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 43645 | LAPS GSTR RSTCV PX W BYP AND SM INT RCNSTN | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 43647 | LAPS IMPLTN/PLCMT GASTRIC NEUROSTIMLTR ELCTRDS ANTRUM | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 43648 | LAPS REVISION/RMVL GASTRIC NEUSTIMLTR ELCTRDS ANTRUM | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 43770 | LAPS GASTRIC RESTRICTIVE PROCEDURE PLACE DEVICE | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 43771 | LAPS GASTRIC RESTRICTIVE PX RVSN DEVICE | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 43772 | LAPS GASTRIC RESTRICTIVE PX REMOVE DEVICE | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 43773 | LAPS GASTRIC RESTRICTIVE PX REMOVE AND RPLCMT DEVICE | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 43774 | LAPS GASTRIC RESTRICTIVE PX REMOVE DVCE AND PORT | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 43775 | LAPS GSTRC RSTRICTIV PX LONGITUDINAL GASTRECTOMY | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 43843 | GSTR RSTCV W O BYP OTH THN VER-BANDED GSTP | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 43845 | GASTRIC RSTCV W PRTL GASTRECTOMY 50-100 CM | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 43846 | GASTRIC RSTCV W BYP W SHORT LIMB 150 CM OR LESS | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 43847 | GASTRIC RSTCV W BYP W SML INTSTN RCNSTN LIMIT ABSRPN | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 43848 | REVISION OPEN GASTRIC RESTRICTIVE PX NOT DEVICE | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 43881 | IMPLTN/RPLCMT GASTRIC NRSTIMLTR ELCTRDS ANTRUM OPEN | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 43882 | RVSN/RMVL GASTRIC NRSTIMLTR ELCTRDES ANTRUM OPEN | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |

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| 43886 | GSTR RSTCV PX OPN REVJ SUBQ PORT COMPONENT ONLY | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 43887 | GSTR RSTCV PX OPN RMVL SUBQ PORT COMPONENT ONLY | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 43888 | GSTR RSTCV OPN RMVL AND RPLCMT SUBQ PORT | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 47610 | CHOLECYSTECTOMY W EXPLORATION COMMON DUCT | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 47612 | CHOLECYSTECTOMY EXPL DUCT CHOLEDOCHOENTEROSTOMY | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 49904 | OMENTAL FLAP EXTRA-ABDOMINAL | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 49906 | FREE OMENTAL FLAP W MICROVASCULAR ANAST | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 50590 | LITHOTRIPSY XTRCORP SHOCK WAVE | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 52441 | CYSTO INSERTION TRANSPROSTATIC IMPLANT SINGLE | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 52649 | LASER ENUCLEATION PROSTATE W MORCELLATION | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 53410 | URETHROPLASTY 1 STG RECNST MALE ANTERIOR URETHRA | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | No prior auth required for service when associated with a cancer diagnosis. | |
| 53420 | URTP 2-STG RCNSTJ/RPR PROSTAT/URETHRA 1ST STAGE | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | No prior auth required for service when associated with a cancer diagnosis. | |
| 53425 | URTP 2-STG RCNSTJ/RPR PROSTAT/URETHRA 2ND STAGE | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | No prior auth required for service when associated with a cancer diagnosis. | |
| 53430 | URETHROPLASTY RCNSTN FEMALE URETHRA | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | No prior auth required for service when associated with a cancer diagnosis. | |
| 53451 | PERIURETHRAL TPRNL ADJTBL BALO CNTNC DEV BI INSJ | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 53452 | PERIURETHRL TPRNL ADJTBL BALO CNTNC DEV UNI INSJ | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 53453 | PERIURETHRAL TPRNL ADJTBL BALO CNTNC DEV RMVL EA | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 53454 | PERIURETHRAL TPRNL ADJTBL BALO CNTNC DEV ADJMT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 53850 | TRURL DSTRJ PRSTATE TISS MICROWAVE THERMOTH | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 53852 | TRURL DSTRJ PRSTATE TISS RF THERMOTH | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 53854 | TRURL DSTRJ PROSTATE TISS RF WV THERMOTHERAPY | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 53865 | CYSTOURETHROSCOPY INS TEMP PROS IMPL/STENT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 54125 | AMPUTATION PENIS COMPLETE | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | No prior auth required for service when associated with a cancer diagnosis. | |
| 54401 | INSRTN PENILE PROSTHESS INFLATABLE SELF-CONTAINED | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 54405 | INSRTN MULTI-COMPONENT INFLATABLE PENILE PROSTHSS | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 54410 | RMVL AND RPLCMT INFLATABLE PENILE PROSTH SAME SESSN | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | No prior auth required for service when associated with a cancer diagnosis. | |
| 54411 | RMVL AND RPLCMT ALL CMPNNTS INFLTBL PENILE PROSTH INFECTED FIELD | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | No prior auth required for service when associated with a cancer diagnosis. | |
| 54416 | RMVL & RPLCMT NON-NFLTBL NFLTBL PENILE PROSTHESIS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | No prior auth required for service when associated with a cancer diagnosis. | |
| 54417 | RMVL AND RPLCMT PENILE PROSTHESIS INFECTED FIELD | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | No prior auth required for service when associated with a cancer diagnosis. | |
| 54520 | ORCHIECTOMY SIMPLE SCROTAL/INGUINAL APPROACH | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | No prior auth required for service when associated with a cancer diagnosis. | |
| 54690 | LAPAROSCOPY SURGICAL ORCHIECTOMY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | No prior auth required for service when associated with a cancer diagnosis. | |
| 55175 | SCROTOPLASTY SIMPLE | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | No prior auth required for service when associated with a cancer diagnosis. | |
| 55180 | SCROTOPLASTY COMPLICATED | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | No prior auth required for service when associated with a cancer diagnosis. | |
| 55866 | LAPS PROSTECT RETROPUBIC RAD W/NRV SPARING ROBOT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | No prior auth required for service when associated with a cancer diagnosis. | |
| 55867 | LPRSCOPY, SRGCL PRSTTECTOMY, SMPLE SUBTOTL (NCLDNG CTRL OF PSTOPRTVE BLEEDING, VSCTOMY, MEATOTMY, URTHRL CALBRTN AND/OR DLTION, AND NTERNL URTHROTOMY), NCLUDS RBTC ASISTNCE, WHN PRFRMD | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | No prior auth required for service when associated with a cancer diagnosis. | |
| 55870 | ELECTROEJACULATION | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| 55874 | TRANSPERINEAL PLCMNT BIODEGRADABLE MATRL 1 MLT NJX | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 55880 | TRANSRECTAL ABLTN MAL PRSTRTE TISSUE HIFU W/US | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 55970 | INTERSEX SURG MALE FEMALE | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | No prior auth required for service when associated with a cancer diagnosis. | |
| 55980 | INTERSEX SURG FEMALE MALE | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | No prior auth required for service when associated with a cancer diagnosis. | |
| 56625 | VULVECTOMY SIMPLE COMPLETE | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | No prior auth required for service when associated with a cancer diagnosis. | |
| 56800 | PLASTIC REPAIR INTROITUS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | No prior auth required for service when associated with a cancer diagnosis. | |
| 56805 | CLITOROPLASTY INTERSEX STATE | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | No prior auth required for service when associated with a cancer diagnosis. | |
| 57106 | VAGINECTOMY PARTIAL REMOVAL VAGINAL WALL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | No prior auth required for service when associated with a cancer diagnosis. | |
| 57110 | VAGINECTOMY COMPLETE REMOVAL VAGINAL WALL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | No prior auth required for service when associated with a cancer diagnosis. | |
| 57288 | SLING OPERATION STRESS INCONTINENCE | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |

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|---|---|---|---|---|---|---|
| 57289 | PEREYRA PX W ANTERIOR COLPORRHAPHY | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 57291 | CONSTRUCTION ARTIFICIAL VAGINA W/O GRAFT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | No prior auth required for service when associated with a cancer diagnosis. | |
| 57292 | CONSTRUCTION ARTIFICIAL VAGINA W/GRAFT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | No prior auth required for service when associated with a cancer diagnosis. | |
| 57296 | REVN W RMVL PROSTHETIC VAGINAL GRAFT OPEN ABDML APPRCH | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | No prior auth required for service when associated with a cancer diagnosis. | |
| 57335 | VAGINOPLASTY INTERSEX STATE | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | No prior auth required for service when associated with a cancer diagnosis. | |
| 57426 | REVISION PROSTHETIC VAGINAL GRAFT LAPAROSCOPIC | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | No prior auth required for service when associated with a cancer diagnosis. | |
| 58150 | TOTAL ABDOMINAL HYSTERECT W WO RMVL TUBE OVARY | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 58152 | TOT ABD HYST W WO RMVL TUBE OVARY W COLPURETHRXY | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 58180 | SUPRACERVICAL ABDL HYSTER W WO RMVL TUBE OVARY | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 58200 | TOT ABD HYST W PARAORTIC AND PELVIC LYMPH NODE SAM | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 58210 | RAD ABDL HYSTERECTOMY W BI PELVIC LMPHADENECTOMY | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 58240 | PEL EXNTJ GYNECOLOGIC MAL | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 58260 | VAGINAL HYSTERECTOMY UTERUS 250 GM OR LESS | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 58262 | VAG HYST 250 GM OR LESS W RMVL TUBE AND OVARY | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 58263 | VAG HYST 250 GM OR LESS W RMVL TUBE OVARY W RPR NTRCL | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 58267 | VAG HYST 250 GM OR LESS W COLPO-URTCSTOPEXY | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 58270 | VAGINAL HYSTERECTOMY 250 GM OR LESS W RPR ENTEROCELE | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 58285 | VAGINAL HYSTERECTOMY RADICAL SCHAUTA OPERATION | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 58290 | VAGINAL HYSTERECTOMY UTERUS OVER 250 GM | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 58291 | VAG HYST OVER 250 GM RMVL TUBE AND OVARY | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 58292 | VAG HYST OVER 250 GM RMVL TUBE AND OVARY W RPR ENTRCLE | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 58294 | VAGINAL HYSTERECTOMY OVER 250 GM RPR ENTEROCELE | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 58321 | ARTIFICIAL INSEMINATION INTRA-CERVICAL | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| 58322 | ARTIFICIAL INSEMINATION INTRA-UTERINE | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| 58323 | SPERM WASHING ARTIFICIAL INSEMINATION | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| 58345 | TRANSCERV FALLOPIAN TUBE CATH W WO HYSTOSALPING | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| 58350 | CHROMOTUBATION OVIDUCT W MATERIALS | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 58356 | ENDOMETRIAL CRYOABLATION W US AND ENDOMETRIAL CR | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 58540 | HYSTEROPLASTY RPR UTERINE ANOMALY | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 58541 | LAPAROSCOPY SUPRACERVICAL HYSTERECTOMY 250 GM OR LESS | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 58542 | LAPS SUPRACRV HYSTERECT 250 GM OR LESS RMVL TUBE OVAR | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 58543 | LAPS SUPRACERVICAL HYSTERECTOMY OVER 250 | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 58544 | LAPS SUPRACRV HYSTEREC OVER 250 G RMVL TUBE OVARY | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 58545 | LAPS MYOMECTOMY EXC 1-4 MYOMAS 250 GM OR LESS | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 58546 | LAPS MYOMECTOMY EXC 5 OR GRT MYOMAS OVER 250 GRAMS | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 58550 | LAPS VAGINAL HYSTERECTOMY UTERUS 250 GM OR LESS | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 58552 | LAPS W VAG HYSTERECT 250 GM AND RMVL TUBE AND OVARIES | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 58553 | LAPS W VAGINAL HYSTERECTOMY OVER 250 GRAMS | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 58554 | LAPS VAGINAL HYSTERECT OVER 250 GM RMVL TUBE AND OVAR | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 58570 | LAPAROSCOPY W TOTAL HYSTERECTOMY UTERUS 250 GM OR LESS | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 58571 | LAPS TOTAL HYSTERECT 250 GM OR LESS W RMVL TUBE OVARY | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 58572 | LAPAROSCOPY TOTAL HYSTERECTOMY UTERUS OVER 250 GM | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 58573 | LAPAROSCOPY TOT HYSTERECTOMY OVER 250 G W TUBE OVAR | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 58660 | LAPAROSCOPY W LYSIS OF ADHESIONS | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 58661 | LAPAROSCOPY W RMVL ADNEXAL STRUCTURES | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 58662 | LAPS FULG EXC OVARY VISCERA PERITONEAL SURFACE | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 58672 | LAPAROSCOPY FIMBRIOPLASTY | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 58673 | LAPAROSCOPY SALPINGOSTOMY | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 58720 | SALPINGO-OOPHORECTOMY COMPL PRTL UNI BI SPX | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 58740 | LYSIS OF ADHESIONS SALPINX OVARY | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |

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|---|---|---|---|---|---|---|
| 58750 | TUBOTUBAL ANASTATOMOSIS | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 58752 | TUBOUTERINE IMPLANTATION | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| 58760 | FIMBRIOPLASTY | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| 58770 | SALPINGOSTOMY | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 58940 | OOPHORECTOMY PARTIAL TOTAL UNI BI | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 58970 | FOLLICLE PUNCTURE OOCYTE RETRIEVAL ANY METHOD | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| 58974 | EMBRYO TRANSFER INTRAUTERINE | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| 58976 | GAMETE ZYGOTE EMBRYO FALLOPIAN TRANSFER ANY METHD | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| 61863 | STRTCTC IMPLTJ NSTIM ELTRD W O RECORD 1ST ARRAY | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 61867 | STRTCTC IMPLTJ NSTIM ELTRD W RECORD 1ST ARRAY | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 61885 | INSJ RPLCMT CRANIAL NEUROSTIM PULSE GENERATOR | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 61886 | INSJ RPLCMT CRANIAL NEUROSTIM GENER 2 OR GRT ELTRDS | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 62324 | NJX CONTINUOUS INFUSION OR INTERMITTENT BOLUS PLACEMENT DX/THER SBST INTRLMNR CRV/THRC W/O IMG GDN | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 62325 | NJX CONTINUOUS INFUSION OR INTERMITTENT BOLUS DX/THER SBST INTRLMNR CRV/THRC W/IMG GDN | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 62326 | NJX CONTINUOUS INFUSION OR INTERMITTENT BOLUS DX/THER SBST INTRLMNR LMBR/SAC W/O IMG GDN | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 62327 | NJX CONTINUOUS INFUSION OR INTERMITTENT BOLUS DX THER SBST INTRLMNR LMBR SAC W IMG GDN | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 62380 | NDSC DCMPRN SPINAL CORD 1 W LAMOT NTRSPC LUMBAR | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 63001 | LAM W O FACETEC FORAMOT DSKC 1 2 VRT SEG CRV | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 63003 | LAMINECTOMY W O FFD 1 2 VERT SEG THORACIC | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 63005 | LAMINECTOMY W O FFD 1 2 VERT SEG LUMBAR | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 63011 | LAMINECTOMY W O FFD 1 2 VERT SEG SACRAL | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 63012 | LAMINECTOMY W RMVL ABNORMAL FACETS LUMBAR | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 63015 | LAMINECTOMY W O FFD OVER 2 VERT SEG CERVICAL | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 63016 | LAMINECTOMY W O FFD OVER 2 VERT SEG THORACIC | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 63017 | LAMINECTOMY W O FFD OVER 2 VERT SEG LUMBAR | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 63020 | LAMNOTMY INCL W DCMPRSN NRV ROOT 1 INTRSPC CERVC | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 63030 | LAMNOTMY INCL W DCMPRSN NRV ROOT 1 INTRSPC LUMBR | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 63040 | LAMOT PRTL FFD EXC DISC REEXPL 1 NTRSPC CERVICAL | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 63042 | LAMOT PRTL FFD EXC DISC REEXPL 1 NTRSPC LUMBAR | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 63045 | LAM FACETECTOMY AND FORAMOTOMY 1 SEGMENT CERVICAL | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 63046 | LAM FACETECTOMY AND FORAMOTOMY 1 SEGMENT THORACIC | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 63047 | LAM FACETECTOMY AND FORAMOTOMY 1 SEGMENT LUMBAR | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 63048 | LAM FACETECTOMY AND FORAMTOMY 1 SGM EA CRV THRC/LMBR | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 63050 | LAMOP CERVICAL W DCMPRN SPI CORD 2 OR GRT VERT SEG | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 63051 | LAMOPLASTY CERVICAL DCMPRN CORD 2 OR GRT SEG RCNSTJ | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 63052 | LAM FACETEC/FORAMOT DRG ARTHRD LUMBAR 1 VRT SGM | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 63053 | LAM FACETEC/FORAMOT DRG ARTHRD LMBR EA ADDL SGM | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 63055 | TRANSPEDICULAR DCMPRN SPINAL CORD 1 SEG THORACIC | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 63056 | TRANSPEDICULAR DCMPRN SPINAL CORD 1 SEG LUMBAR | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 63057 | TRANSPEDICULAR DCMPRN 1 SEG EA THORACIC/LUMBAR | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 63064 | COSTOVERTEBRAL DCMPRN SPINAL CORD THORACIC 1 SEG | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 63075 | DISCECTOMY ANT DCMPRN CORD CERVICAL 1 NTRSPC | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 63076 | DISCECTOMY ANT DCMPRN CORD CERVICAL EA NTRSPC | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 63077 | DISCECTOMY ANT DCMPRN CORD THORACIC 1 NTRSPC | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 63081 | VERTEBRAL CORPECTOMY ANT DCMPRN CERVICAL 1 SEG | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 63087 | VCRPEC THORACOLMBR DCMPRN LWR THRC LMBR 1 SEG | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |

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|---|---|---|---|---|---|---|
| 63090 | VCRPEC TRANSPRTL RPR DCMPRN THRC LMBR SAC 1 SEG | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 63300 | VCRPEC LES 1 SGM XDRL CERVICAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 63304 | VERTEBRAL CORPECTOMY EXC LES 1 SEG IDRL CERVICAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 63308 | VERTEBRAL CORPECTOMY EXC INDRL LES EACH SEG | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 64553 | PRQ IMPLTJ NEUROSTIMULATOR ELTRD CRANIAL NERVE | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 64568 | INC IMPLTJ CRNL NRV NSTIM ELTRDS AND PULSE GENER | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 64569 | REVISION REPLMT NEUROSTIMLATOR ELTRD CRANIAL NRV | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 64570 | REMOVAL CRNL NRV NSTIM ELTRDS AND PULSE GENERATO | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 64582 | OPEN IMPLTJ HPGLSL NRV NSTIM RA PG AND RESPIR SENSOR | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 64584 | REMOVAL HYPOGLOSSAL NERVE NSTIM RA PG AND RESPIR SNR | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 64590 | INSERTION RPLCMT PERIPHERAL GASTRIC NPGR | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 64912 | NERVE REPAIR W NERVE ALLOGRAFT FIRST STRAND | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 65771 | RADIAL KERATOTOMY | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 65775 | CRNL WEDGE RESCJ CORRJ INDUCED ASTIGMATISM | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 69714 | IMPLTJ OSSEOINTEGRATED TEMPORAL BONE W MASTOID | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 69716 | IMPLTJ OI IMPLT SKULL MAG TC ATTACHMENT ESP | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 69729 | IMPL OI IMPLT SKULL MAG TC ATTACHMENT ESP GT or equal to 1 | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 69730 | RPLCMT OI IMPLT SKULL MAG TC ATTACHMENT ESP GT or equal to | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 69930 | COCHLEAR DEVICE IMPLANTATION W WO MASTOIDECTOMY | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 76948 | US GUIDANCE ASPIRATION OVA IMG S AND I | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| 89250 | CUL OOCYTE/EMBRYO LT 4 DAYS | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| 89251 | CUL OOCYTE/EMBRYO LT 4 D CO-CULT OCYTE/EMBRY | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| 89253 | ASSTD EMBRYO HATCHING MICROTQS ANY METH | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| 89254 | OOCYTE ID FROM FOLLICULAR FLU | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| 89255 | PREPJ EMBRYO TR | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| 89257 | SPRM ID FROM ASPIR OTH/THN SEMINAL | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| 89258 | CRYOPRSRV EMBRYO | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| 89259 | CRYOPRSRV SPRM | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| 89260 | SPRM ISOL SMPL PREP INSEMINATION/DX SEMEN ALYS | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| 89261 | SPRM ISOL CPLX PREP INSEMINATION/DX SEMEN ALYS | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| 89264 | SPRM ID FROM TSTIS TISS FRSH/CRYOPRSRVD | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| 89268 | INSEMINATION OOCYTES | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| 89272 | EXTND CUL OOCYTE/EMBRYO 4-7 DAYS | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| 89280 | ASSTD FERTILIZATION MICROTQ LT EQUAL 10 OOCYTES | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| 89281 | ASSTD FERTILIZATION MICROTQ GT 10 OOCYTES | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| 89290 | BX OOCYTE MICROTQ LT or equal to 5 EMBRY | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| 89291 | BX OOCYTE MICROTQ GT 5 EMBRY | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| 89352 | THAWING CRYOPRESERVED EMBRYO | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| 89353 | THAWING CRYOPRESERVED SPERM/SEMEN EACH ALIQUOT | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| 89356 | THAWING CRYOPRESERVED OOCYTES EACH ALIQUOT | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| 92941 | PRQ TRLUML CORONRY TOT OCCLUS REVASC MI ONE VSL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 92970 | CARDIOASSIST-METH CIRCULATORY ASSIST INTERNAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 92971 | CARDIOASSIST-METH CIRCULATORY ASSIST EXTERNAL | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |

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| 92975 | THROMBOLYSIS INTRACORONARY NFS SLCTV ANGRPH | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 92977 | THROMBOLYSIS CORONARY INTRAVENOUS INFUSION | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 93025 | MICROVOLT T-WAVE ASSESS VENTRICULAR ARRHYTHMIAS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 93228 | XTRNL MOBILE CV TELEMETRY W/I&REPORT 30 DAYS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 93229 | XTRNL MOBILE CV TELEMETRY W/TECHNICAL SUPPORT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 93264 | REMOTE MNTR WIRELESS P-ART PRS SNR UP TO 30 D | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 93580 | PRQ TCAT CLSR CGEN INTRATRL COMUNICAJ W/IMPLT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 93581 | PRQ TCAT CLSR CGEN VENTR SEPTAL DFCT W/IMPLT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 93582 | PERCUTAN TRANSCATH CLOSURE PAT DUCT ARTERIOSUS | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 93583 | PERCUTANEOUS TRANSCATHETER SEPTAL REDUCTION THER | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 93631 | INTRAOP EPICAR AND ENDOCAR PACG AND MAPG | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 96567 | PDT DSTR PRMLG LES SKN ILLUM ACTIVJ PER DAY | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 96570 | PDT NDSC ABL ABNOR TISS VIA ACTIVJ RX 30 MIN | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 96571 | PDT NDSC ABL ABNOR TISS VIA ACTIVJ RX A 15 MIN | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 96573 | PDT DSTR PRMLG LES SKN ILLUM ACTIVJ BY PHYS QHP | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 96574 | DEBRIDEMENT PRMLG HYPERKERATOTIC LES W PDT | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 96900 | ACTINOTHERAPY ULTRAVIOLET LIGHT | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 96902 | MCRSCP XM HAIR PLUCK CLIP FOR CNTS STRUCT ABNORM | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 96910 | PHOTOCHEMOTX TAR AND UVB PETROLATUM UVB | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 96912 | PHOTOCHEMOTX PSORALENS AND ULTRAVIOLET PUVA | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 96913 | PHOTOCHEMOTHERAPY DERMATOSES 4-8 HRS SUPERVISION | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 96920 | LASER SKIN DISEASE PSORIASIS TOT AREA UNDER 250 SQ CM | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 96921 | LASER SKIN DISEASE PSORIASIS 250-500 SQ CM | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 96922 | LASER SKIN DISEASE PSORIASIS OVER 500 SQ CM | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 96932 | RCM CELULR AND SUBCELULR SKN IMGNG IMG ACQUISITION | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 96933 | RCM CELULR AND SUBCELULR SKN IMGNG I AND R 1ST LES | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 0402T | COLLAGEN CROSS-LINKING OF CORNEA MED SEPARATE | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| 0479T | FRACTIONAL ABL LSR FENESTRATION FIRST 100 SQCM | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |

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|---|---|---|---|---|---|---|
| 0480T | FRACTIONAL ABL LSR FENESTRATION EA ADDL 100 SQCM | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| 0707T | NJX BONE SUB MATRL INTO SUBCHONDRAL BONE DEFECT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| C2616 | BRACHYTHERAPY NONSTRANDED YTTRIUM-90 PER SOURCE | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| C9740 | CYSTURETHRSCPY INSRT TRANSPROSTAT IMPL; 4 OR GRT IMPL | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| C9757 | LAMINOTOMY DECOMP NERVE ROOT; 1 INTERSPACE LUMB | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| C9761 | CYSTO URS &/PYELOSCPY LITH & VAC ASPIR KDNY COLLCTN SYSTM | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| C9765 | REV EVAR ANY VES;IV LITHOTRIPSY AND TL STENT PLCMT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| C9766 | REV EVAR ANY VES);IV LITHOTRIPSY AND ATHERECTOMY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| C9767 | REV EVAR ANY VES;IV LITHO AND TL STNT PLCMT AND ATHEREC T | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| C9772 | RVSC EVAR OPN/PERC TIB/PER ART IVASC LITHOTRIPSY | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| C9773 | RVSC EVAR OPEN/PC TIBIAL/PA;IVASC LITH AND TL SP | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| C9774 | RVSC EVAR OPN/PERQ TIB/PER ART;IVASC LITH AND ATHREC | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| C9775 | RVSC EVAR OPN/P TIB/PA;IVASC LITH AND TL STNT PL AND ATH | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| J7330 | AUTOLOGOUS CULTURED CHONDROCYTES IMPLANT | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| S2095 | TRNSCATH OCCL EMBOLIZ TUMR DESTRUC PERQ METH USI | OP Hosp/Amb Surgery Center (ASC) procedures | Y | | | |
| S2118 | METL-ON-METL TOT HIP RESRFC ACETAB AND FEM CMPNT | OP Hosp/Amb Surgery Center (ASC) Procedures | Y | | | |
| S4011 | IN VITRO FERTILIZATION; | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| S4013 | CMPL CYCLE GAMETE INTRAFALLOPIAN TRNSF CASE RATE | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| S4014 | CMPL CYCLE ZYGOTE INTRAFALLOPIAN TRNSF CASE RATE | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| S4015 | CMPL IN VITRO FERTILIZATION CYCLE CASE RATE NOS | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| S4016 | FROZEN IN VITRO FERTILIZATION CYCLE CASE RATE | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| S4017 | INCPL CYCLE TX CANCELED PRIOR TO STIM CASE RATE | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| S4018 | FRZN EMB TRANS PROC CANCEL BEFR TRANS CASE RATE | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| S4020 | IVF PROC CANCELLED BEFORE ASPIRATION CASE RATE | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| S4021 | IVF PROC CANCELLED AFTER ASPIRATION CASE RATE | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| S4022 | ASSISTED OOCYTE FERTILIZATION CASE RATE | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| S4023 | DONOR EGG CYCLE INCOMPLETE CASE RATE | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| S4025 | DONOR SERVICES IN VITRO FERTILIZATION CASE RATE | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| S4028 | MICROSURGICAL EPIDIDYMAL SPERM ASPIRATION | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| S4035 | STIM INTRAUTERINE INSEMINATION CASE RATE | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| S4037 | CRYOPRESERVED EMBRYO TRANSFER CASE RATE | OP Hosp/Amb Surgery Center (ASC) Procedures | | | | |
| 27278 | ARTHRD SI JT PERQ IMG GDN INCL PLMT IARTIC IMPLT W/O PLCMNT OF TRNFXTN DVCE | Pain Management Procedures | Y | | | |
| 27279 | ARTHRODESIS SACROILIAC JOINT PERCUTANEOUS | Pain Management Procedures | Y | | | |
| 62263 | PRQ LYSIS EPIDURAL ADHESIONS MULT SESS 2 OR GRT DAYS | Pain Management Procedures | Y | | | |
| 62264 | PRQ LYSIS EPIDURAL ADHESIONS MULT SESSIONS 1 DAY | Pain Management Procedures | Y | | | |
| 62320 | NJX DX/THER SBST INTRLMNR CRV/THRC W/O IMG GDN | Pain Management Procedures | Y | | | |
| 62321 | NJX DX/THER SBST INTRLMNR CRV/THRC W/IMG GDN | Pain Management Procedures | Y | | | |
| 62322 | NJX DX THER SBST INTRLMNR LMBR SAC W O IMG GDN | Pain Management Procedures | Y | | | |
| 62323 | NJX DX THER SBST INTRLMNR LMBR SAC W IMG GDN | Pain Management Procedures | Y | | | |
| 62351 | IMPLTJ REVJ RPSG ITHCL EDRL CATH W LAM | Pain Management Procedures | Y | | | |
| 62360 | IMPLTJ RPLCMT ITHCL EDRL DRUG NFS SUBQ RSVR | Pain Management Procedures | Y | | | |
| 62361 | IMPLTJ RPLCMT FS NON-PRGRBL PUMP | Pain Management Procedures | Y | | | |
| 62362 | IMPLTJ RPLCMT ITHCL EDRL DRUG NFS PRGRBL PUMP | Pain Management Procedures | Y | | | |
| 63650 | PRQ IMPLTJ NSTIM ELECTRODE ARRAY EPIDURAL | Pain Management Procedures | Y | | | |
| 63655 | LAM IMPLTJ NSTIM ELTRDS PLATE PADDLE EDRL | Pain Management Procedures | Y | | | |
| 63663 | REVJ INCL RPLCMT NSTIM ELTRD PRQ RA INCL FLUOR | Pain Management Procedures | Y | | | |
| 63664 | REVJ INCL RPLCMT NSTIM ELTRD PLT PDLE INCL FLUOR | Pain Management Procedures | Y | | | |
| 63685 | INSJ RPLCMT SPI NPGR DIR INDUXIVE COUPLING | Pain Management Procedures | Y | | | |
| 63688 | REVJ RMVL IMPLANTED SPINAL NEUROSTIM GENERATOR | Pain Management Procedures | Y | | | |

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| 64450 | INJECTION ANES OTHER PERIPHERAL NERVE BRANCH | Pain Management Procedures | Y | | No PA required in office or ASC setting. PA required if done in hospital setting outside of another procedure. No PA required if combined with another surgical procedure. | |
| 64451 | INJECTION AA AND STRD NERVES NRVTG SI JOINT W IMG | Pain Management Procedures | Y | | | |
| 64454 | INJECTION AA AND STRD GENICULAR NRV BRANCHES W IMG | Pain Management Procedures | Y | | | |
| 64479 | NJX ANES AND STRD W IMG TFRML EDRL CRV THRC 1 LVL | Pain Management Procedures | Y | | | |
| 64480 | NJX ANES AND STRD W IMG TFRML EDRL CRV THRC EA LV | Pain Management Procedures | Y | | | |
| 64483 | NJX ANES AND STRD W IMG TFRML EDRL LMBR SAC 1 LVL | Pain Management Procedures | Y | | | |
| 64484 | NJX ANES AND STRD W IMG TFRML EDRL LMBR SAC EA LV | Pain Management Procedures | Y | | | |
| 64490 | NJX DX THER AGT PVRT FACET JT CRV THRC 1 LEVEL | Pain Management Procedures | Y | | | |
| 64491 | NJX DX THER AGT PVRT FACET JT CRV THRC 2ND LEVEL | Pain Management Procedures | Y | | | |
| 64492 | NJX DX THER AGT PVRT FACET JT CRV THRC 3 PLUS LEVEL | Pain Management Procedures | Y | | | |
| 64493 | NJX DX THER AGT PVRT FACET JT LMBR SAC 1 LEVEL | Pain Management Procedures | Y | | | |
| 64494 | NJX DX THER AGT PVRT FACET JT LMBR SAC 2ND LEVEL | Pain Management Procedures | Y | | | |
| 64495 | NJX DX THER AGT PVRT FACET JT LMBR SAC 3 PLUS LEVEL | Pain Management Procedures | Y | | | |
| 64624 | DESTRUCTION NEUROLYTIC AGT GENICULAR NERVE W IMG | Pain Management Procedures | Y | | | |
| 64625 | RADIOFREQUENCY ABLTJ NRV NRVTG SI JT W IMG GDN | Pain Management Procedures | Y | | | |
| 64628 | THERMAL DSTRJ INTRAOSSEOUS BVN 1ST 2 LMBR/SAC | Pain Management Procedures | Y | | | |
| 64633 | DSTR NROLYTC AGNT PARVERTEB FCT SNGL CRVCL THORA | Pain Management Procedures | Y | | | |
| 64634 | DSTR NROLYTC AGNT PARVERTEB FCT ADDL CRVCL THORA | Pain Management Procedures | Y | | | |
| 64635 | DSTR NROLYTC AGNT PARVERTEB FCT SNGL LMBR SACRAL | Pain Management Procedures | Y | | | |
| 64636 | DSTR NROLYTC AGNT PARVERTEB FCT ADDL LMBR SACRAL | Pain Management Procedures | Y | | | |
| 64640 | DSTRJ NEUROLYTIC AGENT OTHER PERIPHERAL NERVE | Pain Management Procedures | Y | | | |
| 92507 | TX SPEECH LANG VOICE COMMN AND AUDITORY PROC IND | Physical, Occupational, and Speech Therapy | Y | | For ST, PA required after initial evaluation + 6 visits/year. | |
| 92508 | TX SPEECH LANGUAGE VOICE COMMN AUDITRY 2 OR MORE INDIVL | Physical, Occupational, and Speech Therapy | Y | | For ST, PA required after initial evaluation + 6 visits/year. | |
| 92526 | TX SWALLOWING DYSFUNCTION &/ORAL FUNCTN FEEDING | Physical, Occupational, and Speech Therapy | Y | | | |
| 93797 | OUTPATIENT CARDIAC REHAB W/CONT ECG MONITOR | Physical, Occupational, and Speech Therapy | Y | | Allow first visit for cardiopulmonary rehab without PA. All additional visits will require PA where covered. | |
| 93798 | OUTPATIENT CARDIAC REHAB W/O CONT ECG MONITOR | Physical, Occupational, and Speech Therapy | Y | | Allow first visit for cardiopulmonary rehab without PA. All additional visits will require PA where covered. | |
| 94625 | PHYS/QHP SVCS OP PULM REHAB WO CONT OXIMTRY MNTR | Physical, Occupational, and Speech Therapy | Y | | Allow first visit for cardiopulmonary rehab without PA. All additional visits will require PA where covered. | |
| 94626 | PHYS/QHP SVCS OP PULM REHAB W/CONT OXIMTRY MNTR | Physical, Occupational, and Speech Therapy | Y | | Allow first visit for cardiopulmonary rehab without PA. All additional visits will require PA where covered. | |
| 97110 | THERAPEUTIC PX 1/> AREAS EACH 15 MIN EXERCISES | Physical, Occupational, and Speech Therapy | Y | | For PT/OT, PA required after initial evaluation + 12 visits/year (12 visits allowed for each discipline). | |
| 97112 | THER PX 1/> AREAS EACH 15 MIN NEUROMUSC REEDUCAN | Physical, Occupational, and Speech Therapy | Y | | For PT/OT, PA required after initial evaluation + 12 visits/year (12 visits allowed for each discipline). | |
| 97113 | THER PX 1 OR MORE AREAS EACH 15 MIN AQUA THRPY W/EXERCSS | Physical, Occupational, and Speech Therapy | Y | | For PT/OT, PA required after initial evaluation + 12 visits/year (12 visits allowed for each discipline). | |
| 97116 | THER PX 1 OR MORE AREAS EA 15 MIN GAIT TRAING W/STAIR | Physical, Occupational, and Speech Therapy | Y | | For PT/OT, PA required after initial evaluation + 12 visits/year (12 visits allowed for each discipline). | |
| 97129 | THER IVNTJ COG FUNCJ CNTCT 1ST 15 MINUTES | Physical, Occupational, and Speech Therapy | Y | | For PT/OT, PA required after initial evaluation + 12 visits/year (12 visits allowed for each discipline). | |
| 97130 | THER IVNTN COG FUNCJ CNTCT EA ADDL 15 MINUTES | Physical, Occupational, and Speech Therapy | Y | | For PT/OT, PA required after initial evaluation + 12 visits/year (12 visits allowed for each discipline). | |
| 97140 | MANUAL THERAPY TQS 1/> REGIONS EACH 15 MINUTES | Physical, Occupational, and Speech Therapy | Y | | For PT/OT, PA required after initial evaluation + 12 visits/year (12 visits allowed for each discipline). | |
| 97150 | THERAPEUTIC PROCEDURES GROUP 2 OR MORE INDVDUALS | Physical, Occupational, and Speech Therapy | Y | | For PT/OT, PA required after initial evaluation + 12 visits/year (12 visits allowed for each discipline). | |

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| 97530 | THERAPEUT ACTVITY DIRECT PT CONTACT EACH 15 MIN | Physical, Occupational, and Speech Therapy | Y | | For PT/OT, PA required after initial evaluation + 12 visits/year (12 visits allowed for each discipline). | |
| 97533 | SENSORY INTEGRATIVE TECHNIQUES EACH 15 MINUTES | Physical, Occupational, and Speech Therapy | Y | | For PT/OT, PA required after initial evaluation + 12 visits/year (12 visits allowed for each discipline). | |
| 97535 | SELF-CARE/HOME MGMT TRAINING EACH 15 MINUTES | Physical, Occupational, and Speech Therapy | Y | | For PT/OT, PA required after initial evaluation + 12 visits/year (12 visits allowed for each discipline). | |
| 97542 | WHEELCHAIR MGMT EA 15 MIN | Physical, Occupational, and Speech Therapy | Y | | For PT/OT, PA required after initial evaluation + 12 visits/year (12 visits allowed for each discipline). | |
| 97750 | PHYSICAL PERFORMANCE TEST/MSRMNT W RPRT EA 15 MIN | Physical, Occupational, and Speech Therapy | Y | | For PT/OT, PA required after initial evaluation + 12 visits/year (12 visits allowed for each discipline). | |
| 97755 | ASSTV TECHNOL ASSMT DIR CNTCT W/REPRT EA 15 MIN | Physical, Occupational, and Speech Therapy | Y | | For PT/OT, PA required after initial evaluation + 12 visits/year (12 visits allowed for each discipline). | |
| 97763 | ORTHOTICS/PROSTH MGMT &/TRAINNG SBSQ ENCTR 15 MIN | Physical, Occupational, and Speech Therapy | Y | | For PT/OT, PA required after initial evaluation + 12 visits/year (12 visits allowed for each discipline). | |
| G0129 | OCCUP TX REQ SKILLS QUAL OCCUP TRPST PER SESSION | Physical, Occupational, and Speech Therapy | Y | | For PT/OT, PA required after initial evaluation + 12 visits/year (12 visits allowed for each discipline). | |
| G0237 | MUSCLES FACE TO FACE ONE ON ONE EACH 15 MINUTES | Physical, Occupational, and Speech Therapy | Y | | Allow first visit for cardiopulmonary rehab without PA. All additional visits will require PA where covered. | |
| G0238 | TX PROC IMPRV RESP FUNCT NOT G0237 FCE-FCE 15MIN | Physical, Occupational, and Speech Therapy | Y | | Allow first visit for cardiopulmonary rehab without PA. All additional visits will require PA where covered. | |
| G0239 | TX PROC IMPRV RESP FUNCT/INCR RESP MUSC 2 OR GT IND | Physical, Occupational, and Speech Therapy | Y | | Allow first visit for cardiopulmonary rehab without PA. All additional visits will require PA where covered. | |
| G0422 | INTENSIVE CARD REHAB; W/WO CONT ECG MON W/EXER | Physical, Occupational, and Speech Therapy | Y | | Allow first visit for cardiopulmonary rehab without PA. All additional visits will require PA where covered. | |
| G0423 | INTENSIVE CARD REHAB; W/WO CONT ECG MON W/O EXER | Physical, Occupational, and Speech Therapy | Y | | Allow first visit for cardiopulmonary rehab without PA. All additional visits will require PA where covered. | |
| S8990 | PHYSICAL MANIP TX MAINT RATHER THAN RESTORATION | Physical, Occupational, and Speech Therapy | Y | | For PT/OT, PA required after initial evaluation + 12 visits/year (12 visits allowed for each discipline). | |
| S9090 | VERTEBRAL AXIAL DECOMPRESSION PER SESSION | Physical, Occupational, and Speech Therapy | Y | | For PT/OT, PA required after initial evaluation + 12 visits/year (12 visits allowed for each discipline). | |
| S9472 | CARD REHAB PROGM NON-PHYSICIAN PROVIDER PER DIEM | Physical, Occupational, and Speech Therapy | Y | | Allow first visit for cardiopulmonary rehab without PA. All additional visits will require PA where covered. | |
| S9473 | PULM REHAB PROGM NON-PHYSICIAN PROVIDER PER DIEM | Physical, Occupational, and Speech Therapy | Y | | Allow first visit for cardiopulmonary rehab without PA. All additional visits will require PA where covered. | |
| S9476 | VESTIBULAR REHAB PROGM NON-PHYSICIAN PROV-DIEM | Physical, Occupational, and Speech Therapy | Y | | For PT/OT, PA required after initial evaluation + 12 visits/year (12 visits allowed for each discipline). | |
| L0462 | TLSO TRIPLANAR 3 SHELL ANT TO STERNL NOTCH PRFAB | Prosthetics & Orthotics | Y | | | |
| L0480 | TLSO TRIPLANAR 1 PIECE W O INTERFCE LINER CSTM | Prosthetics & Orthotics | Y | | | |
| L0482 | TLSO TRIPLANAR 1 PIECE W INTERFCE LINER CSTM | Prosthetics & Orthotics | Y | | | |
| L0484 | TLSO TRIPLANAR 2 PIECE W O INTERFCE LINER CSTM | Prosthetics & Orthotics | Y | | | |
| L0486 | TLSO TRIPLANAR 2 PIECE W INTERFCE LINER CSTM | Prosthetics & Orthotics | Y | | | |
| L0636 | LSO SAGITTAL-CORONL CNTRL FLEX RIGID POST CUSTOM | Prosthetics & Orthotics | Y | | | |
| L0637 | LUMB-SACRAL ORTHOS SAG-COR CNTRL RIGD A AND P PREFAB | Prosthetics & Orthotics | Y | | | |
| L0640 | LSO SAGITTAL-CORONAL RIGID SHELL PANEL CUSTM FAB | Prosthetics & Orthotics | Y | | | |
| L0650 | LSO SAGITTAL-CORONAL CONTRL RIGD ANT POST PANELS | Prosthetics & Orthotics | Y | | | |
| L0700 | CTLSO ANT-POSTERIOR-LAT CONTROL MOLDED PT MODEL | Prosthetics & Orthotics | Y | | | |
| L0710 | CTLSO ANT-POST-LAT CNTRL MOLD PT-INTRFCE MATL | Prosthetics & Orthotics | Y | | | |
| L0720 | CTLSO A-P-L CONTROL CUSTOM | Prosthetics & Orthotics | Y | | | |
| L1000 | CTLSO INCLUSIVE FURNISHING INIT ORTHOS INCL MDL | Prosthetics & Orthotics | Y | | | |
| L1005 | TENSION BASED SCOLIOSIS ORTHOTIC AND ACCESSORY PADS | Prosthetics & Orthotics | Y | | | |

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| L1200 | TLSO INCLUSIVE FURNISHING INITIAL ORTHOSIS ONLY | Prosthetics & Orthotics | Y | | | |
| L1499 | SPINAL ORTHOTIC NOT OTHERWISE SPECIFIED | Prosthetics & Orthotics | Y | | | |
| L1680 | HIP ORTHOT DYN PELV CONTROL THIGH CUFF CSTM FAB | Prosthetics & Orthotics | Y | | | |
| L1685 | HIP ORTHOS ABDCT CNTRL POSTOP HIP ABDCT CSTM | Prosthetics & Orthotics | Y | | | |
| L1730 | LEGG PERTHES ORTHOTIC SCOTTISH RITE CUSTOM FAB | Prosthetics & Orthotics | Y | | | |
| L1834 | KO WITHOUT KNEE JOINT RIGID CUSTOM FABRICATED | Prosthetics & Orthotics | Y | | | |
| L1840 | KO DEROTATION MEDIAL-LATERAL ACL CUSTOM FAB | Prosthetics & Orthotics | Y | | | |
| L1844 | KNEE ORTHOSIS SINGLE UPRIGHT THIGH AND CALF CUSTOM | Prosthetics & Orthotics | Y | | | |
| L1846 | KNEE ORTHOSIS DOUBLE UPRIGHT THIGH AND CALF CUSTOM | Prosthetics & Orthotics | Y | | | |
| L1860 | KNEE ORTHOS MOD SUPRACONDYLR PROS SOCKT CSTM FAB | Prosthetics & Orthotics | Y | | | |
| L1900 | AFO SPRNG WIRE DORSIFLX ASST CALF BAND CSTM FAB | Prosthetics & Orthotics | Y | | | |
| L1945 | AFO MOLD PT MDL PLSTC RIGD ANT TIBL SECT CSTM | Prosthetics & Orthotics | Y | | | |
| L1950 | ANKLE FOOT ORTHOTIC SPIRAL PLASTIC CUSTOM-FAB | Prosthetics & Orthotics | Y | | | |
| L1970 | AFO PLASTIC WITH ANKLE JOINT CUSTOM FABRICATED | Prosthetics & Orthotics | Y | | | |
| L2000 | KAFO 1 UPRT FREE KNEE FREE ANK SOLID STIRUP CSTM | Prosthetics & Orthotics | Y | | | |
| L2005 | KAFO ANY MATL AUTO LOCK AND SWNG RLSE W ANK JNT CSTM | Prosthetics & Orthotics | Y | | | |
| L2006 | KAF DVC ANY MATERIAL ADJUSTABILITY CUSTOM FAB | Prosthetics & Orthotics | Y | | | |
| L2010 | KAFO 1 UPRT SOLID STIRUP W O KNEE JNT CSTM FAB | Prosthetics & Orthotics | Y | | | |
| L2020 | KAFO DBL UPRT SOLID STIRUP THI AND CALF CSTM FAB | Prosthetics & Orthotics | Y | | | |
| L2030 | KAFO DBL UPRT SOLID STIRUP W O KNEE JNT CSTM | Prosthetics & Orthotics | Y | | | |
| L2034 | KAFO PLASTIC MED LAT ROTAT CNTRL CSTM FAB | Prosthetics & Orthotics | Y | | | |
| L2036 | KAFO FULL PLASTIC DOUBLE UPRIGHT CSTM FAB | Prosthetics & Orthotics | Y | | | |
| L2037 | KAFO FULL PLASTIC SINGLE UPRIGHT CUSTOM FAB | Prosthetics & Orthotics | Y | | | |
| L2038 | KAFO FULL PLASTIC MX-AXIS ANKLE CUSTOM FAB | Prosthetics & Orthotics | Y | | | |
| L2090 | HKAFO UNI TORSION CABLE BALL BEAR CSTM | Prosthetics & Orthotics | Y | | | |
| L2106 | AFO FX ORTHOTIC TIB FX CAST THERMOPLSTC CSTM FAB | Prosthetics & Orthotics | Y | | | |
| L2108 | AFO FX ORTHOTIC TIB FX CAST ORTHOSIS CSTM FAB | Prosthetics & Orthotics | Y | | | |
| L2126 | KAFO FEM FX CAST ORTHOTIC THERMOPLSTC CSTM FAB | Prosthetics & Orthotics | Y | | | |
| L2128 | KAFO FX ORTHOTIC FEM FX CAST ORTHOSIS CSTM FAB | Prosthetics & Orthotics | Y | | | |
| L2350 | ADD LOW EXTREM PROSTHETIC TYPE SOCKT MOLD PT MDL | Prosthetics & Orthotics | Y | | | |
| L2525 | ADD LW EXTRM ISCH M-L BRIM MOLD PT MDL | Prosthetics & Orthotics | Y | | | |
| L2627 | ADD LW EXT PELV PLSTC MOLD PT MDL HIP JNT AND CABLES | Prosthetics & Orthotics | Y | | | |
| L2628 | ADD LW EXT PELV METL FRME RECIP HIP JNT AND CABLES | Prosthetics & Orthotics | Y | | | |
| L2999 | LOWER EXTREMITY ORTHOSES NOT OTHERWISE SPECIFIED | Prosthetics & Orthotics | Y | | | |
| L3900 | WHFO DYN FLEXOR HINGE WRST/FNGR DRIVEN CSTM FAB | Prosthetics & Orthotics | Y | | | |
| L3901 | WHFO DYN FLEXOR HINGE CABLE DRIVEN CSTM FAB | Prosthetics & Orthotics | Y | | | |
| L3904 | WHFO EXTERNAL POWERED ELECTRIC CUSTOM FABRICATED | Prosthetics & Orthotics | Y | | | |
| L3999 | UPPER LIMB ORTHOSIS NOT OTHERWISE SPECIFIED | Prosthetics & Orthotics | Y | | | |
| L4631 | AFO WALK BOOT TYP ROCKR BOTTM ANT TIB SHELL CSTM | Prosthetics & Orthotics | Y | | | |
| L5050 | ANKLE SYMES MOLDED SOCKET SACH FOOT | Prosthetics & Orthotics | Y | | | |
| L5060 | ANK SYMES METL FRME MOLD LEATHR SOCKT ARTIC ANK | Prosthetics & Orthotics | Y | | | |
| L5100 | BELOW KNEE MOLDED SOCKET SHIN SACH FOOT | Prosthetics & Orthotics | Y | | | |
| L5105 | BELOW KNEE PLSTC SOCKT JNT AND THIGH LACER SACH FOOT | Prosthetics & Orthotics | Y | | | |
| L5150 | KNEE DISRTC MOLD SOCKT EXT KNEE JNT SHIN SACH FT | Prosthetics & Orthotics | Y | | | |
| L5160 | KNEE DISARTIC MOLD SOCKT BENT KNEE EXT KNEE JNT | Prosthetics & Orthotics | Y | | | |
| L5200 | ABOVE KNEE MOLD SOCKT 1 AXIS CONSTANT FRICTION | Prosthetics & Orthotics | Y | | | |
| L5210 | ABOVE KNEE SHRT PROSTH NO KNEE JNT NO ANK JNT EA | Prosthetics & Orthotics | Y | | | |
| L5220 | ABOVE KNEE SHORT PROSTH W/ARTIC ANK/FOOT DYN | Prosthetics & Orthotics | Y | | | |
| L5230 | ABOVE KNEE PROXIMAL FEM FOCAL DEFIC SACH FOOT | Prosthetics & Orthotics | Y | | | |
| L5250 | HIP DISARTIC CANADIAN TYPE; MOLD SOCKT HIP JNT | Prosthetics & Orthotics | Y | | | |

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|---|---|---|---|---|---|---|
| L5270 | HIP DISRTC TILT TABLE; MOLD SCKT LOCK HIP JNT | Prosthetics & Orthotics | Y | | | |
| L5280 | HEMIPELVECT CANADIAN TYPE; MOLD SOCKT HIP JNT | Prosthetics & Orthotics | Y | | | |
| L5301 | BELOW KNEE MOLD SOCKET SHIN SACH FT ENDOSKEL SYS | Prosthetics & Orthotics | Y | | | |
| L5312 | KNEE DISARTIC MOLD SOCKET 1 AXIS KNEE SACH FOOT | Prosthetics & Orthotics | Y | | | |
| L5321 | ABOVE KNEE OPEN END SACH FT ENDO SYS 1 AXIS KNEE | Prosthetics & Orthotics | Y | | | |
| L5331 | JOINT SINGLE AXIS KNEE SACH FOOT | Prosthetics & Orthotics | Y | | | |
| L5341 | SINGLE AXIS KNEE SACH FOOT | Prosthetics & Orthotics | Y | | | |
| L5500 | INIT BELOW KNEE PTB SOCKET NON-ALIGN DIR FORMED | Prosthetics & Orthotics | Y | | | |
| L5505 | INIT ABVE KNEE-DISARTC ISCH LEVL SOCKT NON-ALIGN | Prosthetics & Orthotics | Y | | | |
| L5510 | PREP BELOW KNEE PTB SOCKET NON-ALIGN MOLD MODEL | Prosthetics & Orthotics | Y | | | |
| L5520 | PREP BK PTB SCKT NON-ALIGN THERMOPLSTC/ Equal to DIR FORM | Prosthetics & Orthotics | Y | | | |
| L5530 | PREP BK PTB SCKT NON-ALIGN THERMOPLSTC/ Equal to MOLD MDL | Prosthetics & Orthotics | Y | | | |
| L5535 | PREP BELOW KNEE PTB NON-ALIGN PRFAB ADJ OPEN END | Prosthetics & Orthotics | Y | | | |
| L5540 | PREP BK PTB SCKT NON-ALIGN LAMNATD SCKT MOLD MDL | Prosthetics & Orthotics | Y | | | |
| L5560 | PREP AK-DISRTC ISCH LEVL PLASTER SOCKET MOLD MDL | Prosthetics & Orthotics | Y | | | |
| L5570 | PREP AK-DISRTC ISCH LEVL THERMOPLSTC/ Equal to DIR FORMED | Prosthetics & Orthotics | Y | | | |
| L5580 | PREP AK DISARTIC NON-ALIGN THERMOPLSTC/ Equal to MOLD MDL | Prosthetics & Orthotics | Y | | | |
| L5585 | PREP AK-DISARTC NON-ALIGN PRFAB ADJ OPN END SCKT | Prosthetics & Orthotics | Y | | | |
| L5590 | PREP AK-DISARTIC NON-ALIGN LAMINATED SOCKET MOLD | Prosthetics & Orthotics | Y | | | |
| L5595 | PREP HIP DISARTIC-HEMIPELVECT THERMOPLSTC/ Equal to MOLD | Prosthetics & Orthotics | Y | | | |
| L5600 | PREP HIP DISARTIC-HEMIPELVECT LAMINATD SCKT MOLD | Prosthetics & Orthotics | Y | | | |
| L5610 | ADD LW EXTRM ENDO SYS ABVE KNEE HYDRACADENCE SYS | Prosthetics & Orthotics | Y | | | |
| L5611 | ADD LW EXTRM ENDO AK-DISRTC 4-BAR LINK W/FRICT | Prosthetics & Orthotics | Y | | | |
| L5613 | ADD LOW EXTRM ENDO AK-DISARTIC 4-BAR W/HYDRAULIC | Prosthetics & Orthotics | Y | | | |
| L5614 | ADD LOW EXT EXOSKEL SYS AK-DISARTC 4-BAR PNEUMAT | Prosthetics & Orthotics | Y | | | |
| L5616 | ADD LOW EXTRM ENDO AK UNIVERSAL MXPLX SYS FRICT | Prosthetics & Orthotics | Y | | | |
| L5639 | ADDITION LOWER EXTREMITY BELOW KNEE WOOD SOCKET | Prosthetics & Orthotics | Y | | | |
| L5643 | ADD LW EXT HIP DISARTIC FLX INNR SOCKT EXT FRAME | Prosthetics & Orthotics | Y | | | |
| L5649 | ADD LW EXT ISCHIAL CONTAINMENT/NARROW M-L SOCKET | Prosthetics & Orthotics | Y | | | |
| L5651 | ADD LW EXT ABVE KNEE FLXIBLE INNR SOCKT EXT FRME | Prosthetics & Orthotics | Y | | | |
| L5681 | ADD LW EXT BK/AK CST INS CNG/ATYP TRAUM AMP INIT | Prosthetics & Orthotics | Y | | | |
| L5683 | ADD LW EXTR BK/AK CST FAB NO CNGN/TRAUM AMP INIT | Prosthetics & Orthotics | Y | | | |
| L5700 | REPLACEMENT SOCKET BELOW KNEE BK MOLDED PT MODEL | Prosthetics & Orthotics | Y | | | |
| L5701 | REPL SOCKT ABOVE KNEE/KNEE DISARTIC W/ATTCH PLAT | Prosthetics & Orthotics | Y | | | |
| L5702 | REPLCMT SOCKT HIP DISARTIC W/HIP JNT MOLD PT MDL | Prosthetics & Orthotics | Y | | | |
| L5703 | ANKLE SYMES MOLD PT MODEL SACH FOOT REPL ONLY | Prosthetics & Orthotics | Y | | | |
| L5705 | CUSTOM SHAPED PROTECTIVE COVER ABOVE KNEE AK | Prosthetics & Orthotics | Y | | | |
| L5706 | CUSTOM SHAPED PROTECTIVE COVER KNEE DISARTIC | Prosthetics & Orthotics | Y | | | |
| L5707 | CUSTOM SHAPED PROTECTIVE COVER HIP DISARTIC | Prosthetics & Orthotics | Y | | | |
| L5718 | ADD EXOSKL KNEE-SHIN POLYCNTRC FRICT SWING CNTRL | Prosthetics & Orthotics | Y | | | |
| L5722 | ADD EXOSKEL KNEE-SHIN PNEUMAT SWING FRICT CNTRL | Prosthetics & Orthotics | Y | | | |
| L5724 | ADD EXOSKEL KNEE-SHIN FLUID SWING PHASE CNTRL | Prosthetics & Orthotics | Y | | | |
| L5726 | ADD EXOSKEL KNEE-SHIN EXT JOINT FL SWING CNTRL | Prosthetics & Orthotics | Y | | | |
| L5728 | ADD EXOSKEL KNEE-SHIN FLUID SWING AND STANCE CNTRL | Prosthetics & Orthotics | Y | | | |
| L5780 | ADD EXOSKL KNEE-SHIN PNEUMAT/HYDRA PNEUMAT CNTRL | Prosthetics & Orthotics | Y | | | |
| L5781 | ADD LW LIMB PROS RESIDUL LIMB VOL MGMT SYS | Prosthetics & Orthotics | Y | | | |
| L5782 | ADD LW LIMB PROS RESIDUL LIMB MGMT SYS HEVY DUTY | Prosthetics & Orthotics | Y | | | |
| L5783 | ADD LWR EXT USER ADJ MECH RES LIMB VOL MGMT SYS | Prosthetics & Orthotics | Y | | | |
| L5795 | ADD EXOSKEL SYSTEM HIP DISARTIC ULTRA-LGHT MATL | Prosthetics & Orthotics | Y | | | |
| L5814 | ADD ENDOSKEL KNEE-SHIN HYDRAULIC SWING MECH LOCK | Prosthetics & Orthotics | Y | | | |

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| L5816 | ADD ENDOSKEL KNEE-SHIN MECH STANCE PHASE LOCK | Prosthetics & Orthotics | Y | | | |
| L5822 | ADD ENDOSKEL KNEE-SHIN PNEUMAT SWING FRICT CNTRL | Prosthetics & Orthotics | Y | | | |
| L5824 | ADD ENDOSKEL KNEE-SHIN FLUID SWING PHASE CNTRL | Prosthetics & Orthotics | Y | | | |
| L5826 | ADD ENDO KNEE-SHIN HYDRAUL SWNG MIN HI ACTV FRME | Prosthetics & Orthotics | Y | | | |
| L5827 | ENDO KNEE SHIN SINGLE AXIS | Prosthetics & Orthotics | Y | | | |
| L5828 | ADD ENDO KNEE-SHIN FL SWING AND STANCE PHASE CNTRL | Prosthetics & Orthotics | Y | | | |
| L5830 | ADD ENDOSKEL KNEE-SHIN PNEUMAT/SWING PHASE CNTRL | Prosthetics & Orthotics | Y | | | |
| L5840 | ADD ENDO KNEE-SHIN 4-BAR LINK/MX-AXIAL PNEUMAT | Prosthetics & Orthotics | Y | | | |
| L5841 | ADD ENDOSKEL KNEE-SHIN SYS PNEU SW and ST PH CTRL | Prosthetics & Orthotics | Y | | | |
| L5845 | ADD ENDOSKEL KNEE-SHIN STANCE FLX FEATUR ADJ | Prosthetics & Orthotics | Y | | | |
| L5848 | ADD ENDOSKEL KNEE-SHIN SYS FLUID STANCE EXTENSN | Prosthetics & Orthotics | Y | | | |
| L5856 | ADD LOW EXT PROS KNEE-SHIN SYS SWING AND STANCE PHSE | Prosthetics & Orthotics | Y | | | |
| L5857 | ADD LOW EXT PROS KNEE-SHIN SYS SWING PHASE ONLY | Prosthetics & Orthotics | Y | | | |
| L5858 | ADD LW EXT PROS KNEE SHIN SYS STANCE PHASE ONLY | Prosthetics & Orthotics | Y | | | |
| L5859 | ADD LOW EXT PROS KN-SHIN PROG FLX EXT ANY MOTOR | Prosthetics & Orthotics | Y | | | |
| L5930 | ADD ENDOSKEL SYSTEM HIGH ACTV KNEE CONTROL FRAME | Prosthetics & Orthotics | Y | | | |
| L5961 | ADD ENDO SYS POLYCNTRC HIP JOINT ROTATION CNTRL | Prosthetics & Orthotics | Y | | | |
| L5964 | ADD ENDOSKEL AK FLEXIBLE PROTVE OUTR SURF COVER | Prosthetics & Orthotics | Y | | | |
| L5966 | ADD ENDO HIP DISRTC FLXIBL PROTVE OUTR SURF COVR | Prosthetics & Orthotics | Y | | | |
| L5968 | ADD LW LIMB PROSTH MX-AXIAL ANK W/SWING PHASE | Prosthetics & Orthotics | Y | | | |
| L5969 | ADDITION ENDOSKELETAL ANKLE-FOOT/ANK PWR ASSIST | Prosthetics & Orthotics | Y | | | |
| L5973 | ENDOSKEL ANK FOOT SYS MICRPROCSS CONTROL PWR SRC | Prosthetics & Orthotics | Y | | | |
| L5979 | ALL LW EXTRM PRSTH MX-AXL ANK DYN RSPN FT 1 PECE | Prosthetics & Orthotics | Y | | | |
| L5980 | ALL LOWER EXTREMITY PROSTHESES FLEX-FOOT SYSTEM | Prosthetics & Orthotics | Y | | | |
| L5981 | ALL LOWER EXTREM PROSTH FLEX-WALK SYSTEM/EQUAL | Prosthetics & Orthotics | Y | | | |
| L5987 | ALL LW XTRM PRSTH SHNK FT SYS W/VRTCL LOAD PYLN | Prosthetics & Orthotics | Y | | | |
| L5988 | ADD LW LIMB PROSTH VERTCL SHOCK RDUC PYLN FEATUR | Prosthetics & Orthotics | Y | | | |
| L5990 | ADD LOW EXTREM PROSTH USER ADJUSTBLE HEEL HT | Prosthetics & Orthotics | Y | | | |
| L5999 | LOWER EXTREMITY PROSTHESIS NOS | Prosthetics & Orthotics | Y | | | |
| L6000 | PARTIAL HAND THUMB REMAINING | Prosthetics & Orthotics | Y | | | |
| L6010 | PARTIAL HAND LITTLE AND OR RING FINGER REMAINING | Prosthetics & Orthotics | Y | | | |
| L6020 | PARTIAL HAND NO FINGER REMAINING | Prosthetics & Orthotics | Y | | | |
| L6026 | TRANSCARPAL MC PART HAND DISARTICULATION PROS | Prosthetics & Orthotics | Y | | | |
| L6050 | WRST DISARTIC MOLD SOCKET FLEX ELB HNG TRICP PAD | Prosthetics & Orthotics | Y | | | |
| L6055 | WRST DISARTIC MOLD SOCKT W/XPNDABLE INTERFCE | Prosthetics & Orthotics | Y | | | |
| L6100 | BELW ELB MOLD SOCKT FLXIBLE ELB HINGE TRICP PAD | Prosthetics & Orthotics | Y | | | |
| L6110 | BELOW ELBOW MOLDED SOCKET | Prosthetics & Orthotics | Y | | | |
| L6120 | BELW ELB MOLD DBL WALL SCKT STEP-UP HNG 1/2 CUFF | Prosthetics & Orthotics | Y | | | |
| L6130 | BELW ELB STUMP ACTVATD LOCK HINGE HALF CUFF | Prosthetics & Orthotics | Y | | | |
| L6200 | ELB DISARTC MOLD SOCKT OUTSIDE LOCK HINGE FORARM | Prosthetics & Orthotics | Y | | | |
| L6205 | ELB DISARTC MOLD SCKT W/XPND INTRFCE LOCK FORARM | Prosthetics & Orthotics | Y | | | |
| L6250 | ABVE ELB MOLD DBL WALL SCKT INTRL LCK ELB FORARM | Prosthetics & Orthotics | Y | | | |
| L6300 | SHLDR DISARTIC MOLD SOCKET INTRL LOCK ELB FORARM | Prosthetics & Orthotics | Y | | | |
| L6310 | SHOULDER DISARTIC PASSIVE REST COMPLETE PROSTH | Prosthetics & Orthotics | Y | | | |
| L6320 | SHOULDER DISART PASSIVE REST SHOULDER CAP ONLY | Prosthetics & Orthotics | Y | | | |
| L6360 | INTERSCAPULAR THOR PASSIVE REST CMPL PROSTH | Prosthetics & Orthotics | Y | | | |
| L6370 | INTERSCAPULAR THOR PASSIVE REST SHLDR CAP ONLY | Prosthetics & Orthotics | Y | | | |
| L6400 | BE MOLD SCKT ENDOSKEL SYS W/SFT PROSTH TISS SHAP | Prosthetics & Orthotics | Y | | | |
| L6450 | ELB DISRTC MOLD SCKT ENDOSKEL W/SFT PROSTH TISS | Prosthetics & Orthotics | Y | | | |
| L6500 | ABVE ELB MOLD SCKT ENDOSKEL W/SFT PROSTH TISS | Prosthetics & Orthotics | Y | | | |

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| L6550 | SHLDR DISRTC MOLD SCKT ENDOSKEL W/SFT PROS TISS | Prosthetics & Orthotics | Y | | | |
| L6570 | INTRSCAP THOR MOLD SCKT ENDOSKEL W/SFT PROS TISS | Prosthetics & Orthotics | Y | | | |
| L6580 | PREP WRST DISRTC/BELW ELB 1 WALL PLSTC SCKT MOLD | Prosthetics & Orthotics | Y | | | |
| L6582 | PREP WRST DISRTC/BELW ELB 1 WALL SCKT DIR FORMED | Prosthetics & Orthotics | Y | | | |
| L6584 | PREP ELB DISRTC/ABVE ELB 1 WALL PLSTC SOCKT MOLD | Prosthetics & Orthotics | Y | | | |
| L6586 | PREP ELB DISRTC/ABVE ELB 1 WALL SOCKT DIR FORMED | Prosthetics & Orthotics | Y | | | |
| L6588 | PREP SHLDR DISRTC THOR 1 WALL PLSTC SCKT MOLD | Prosthetics & Orthotics | Y | | | |
| L6590 | PREP SHLDR DISRTC THOR 1 WALL SOCKET DIR FORM | Prosthetics & Orthotics | Y | | | |
| L6621 | UP EXTREM PROS ADD FLEXION/EXTENSION WRIST | Prosthetics & Orthotics | Y | | | |
| L6624 | UPPER EXTREMITY ADD FLX/EXT ROTATION WRIST UNIT | Prosthetics & Orthotics | Y | | | |
| L6638 | UP EXT ADD PROS ELEC LOCK ONLY W/MNL PWR ELB | Prosthetics & Orthotics | Y | | | |
| L6646 | UP EXT ADD SHLDR JNT MX PSTN W/BDY/EXT PWR SYS | Prosthetics & Orthotics | Y | | | |
| L6648 | UP EXTREM ADD SHLDR LOCK MECH EXT PWR ACTUATOR | Prosthetics & Orthotics | Y | | | |
| L6693 | UPPER EXTREM ADD LOCK ELB FORARM COUNTERBALANCE | Prosthetics & Orthotics | Y | | | |
| L6696 | ADD UP EXT PROS ELB CSTM CNGN/TRAUMAT AMP INIT | Prosthetics & Orthotics | Y | | | |
| L6697 | ADD UP EXT PROS ELB CSTM NOT CNGN/TRAUM AMP INIT | Prosthetics & Orthotics | Y | | | |
| L6700 | UE ADD EXT POWER MYOEL | Prosthetics & Orthotics | Y | | | |
| L6707 | TERMINAL DEVICE HOOK MECH VOLUNTARY CLOSING | Prosthetics & Orthotics | Y | | | |
| L6708 | TERMINAL DEVICE HAND MECH VOLUNTARY OPENING | Prosthetics & Orthotics | Y | | | |
| L6709 | TERMINAL DEVICE HAND MECH VOLUNTARY CLOSING | Prosthetics & Orthotics | Y | | | |
| L6712 | TERM DVC HOOK MECH VOL CLOS ANY MATL ANY SZ PED | Prosthetics & Orthotics | Y | | | |
| L6713 | TERM DVC HAND MECH VOL OPN ANY MATL ANY SIZE PED | Prosthetics & Orthotics | Y | | | |
| L6715 | TERM DEV MX ARTIC DIGIT W/MOTORS INIT ISSUE/REPL | Prosthetics & Orthotics | Y | | | |
| L6721 | TERM DEVC HOOK/HND HVY-DUTY MECH VOL OPN ANY SZ | Prosthetics & Orthotics | Y | | | |
| L6722 | TERM DEVC HOOK/HAND HVY-DUTY MECH VOL CLOS | Prosthetics & Orthotics | Y | | | |
| L6880 | ELEC HAND SWTCH/MYOELEC CNTRL INDEP ARTC DIG MTR | Prosthetics & Orthotics | Y | | | |
| L6881 | AUTOMATIC GRASP ADD UPPER LIMB ELEC PROSTH DEVC | Prosthetics & Orthotics | Y | | | |
| L6882 | MICRPRROCSS CNTRL FEATUR ADD UP LIMB PROSTH DEVC | Prosthetics & Orthotics | Y | | | |
| L6900 | HAND REST PART HAND W/GLOVE THUMB/1 FNGR REMAIN | Prosthetics & Orthotics | Y | | | |
| L6905 | HAND REST PART HAND W/GLOVE MX FNGR REMAIN | Prosthetics & Orthotics | Y | | | |
| L6910 | HAND REST PART HAND W/GLOVE NO FNGR REMAIN | Prosthetics & Orthotics | Y | | | |
| L6920 | WRST DISARTIC OTTO BOCK/ Equal to SWTCH CNTRL TERM DEVICE | Prosthetics & Orthotics | Y | | | |
| L6925 | WRST DISARTIC OTTO BOCK/ Equal to MYOELEC CNTRL TERM DEVC | Prosthetics & Orthotics | Y | | | |
| L6930 | BELOW ELBOW OTTO BOCK/ Equal to SWITCH CNTRL TERM DEVICE | Prosthetics & Orthotics | Y | | | |
| L6935 | BELOW ELBOW OTTO BOCK/ Equal to MYOELEC CNTRL TERM DEVICE | Prosthetics & Orthotics | Y | | | |
| L6940 | ELBOW DISARTIC OTTO BOCK/ Equal to SWITCH CNTRL TERM DEVC | Prosthetics & Orthotics | Y | | | |
| L6945 | ELB DISARTIC OTTO BOCK/ Equal to MYOELEC CNTRL TERM DEVC | Prosthetics & Orthotics | Y | | | |
| L6950 | ABOVE ELBOW OTTO BOCK/ Equal to SWITCH CNTRL TERM DEVC | Prosthetics & Orthotics | Y | | | |
| L6955 | ABOVE ELBOW OTTO BOCK/ Equal to MYOELEC CNTRL TERM DEVC | Prosthetics & Orthotics | Y | | | |
| L6960 | SHLDR DISARTIC OTTO BOCK/ Equal to SWTCH CNTRL TERM DEVC | Prosthetics & Orthotics | Y | | | |
| L6965 | SHOULDR DISARTIC OTTO BOCK/ Equal to MYOELEC CNTRL TERM | Prosthetics & Orthotics | Y | | | |
| L6970 | INTERSCAP-THOR OTTO BOCK/ Equal to SWTCH CNTRL TERM DEVC | Prosthetics & Orthotics | Y | | | |
| L6975 | INTERSCAP-THOR OTTO BOCK/ Equal to MYOELEC CNTRL TERM DVC | Prosthetics & Orthotics | Y | | | |
| L7007 | ELECTRIC HAND SWITCH/MYOELECTRIC CONTROL ADULT | Prosthetics & Orthotics | Y | | | |
| L7008 | ELECTRIC HAND SWITCH/MYOELECTRIC CNTRL PEDIATRIC | Prosthetics & Orthotics | Y | | | |
| L7009 | ELECTRIC HOOK SWITCH/MYOELECTRIC CONTROL ADULT | Prosthetics & Orthotics | Y | | | |
| L7040 | PREHENSILE ACTUATOR SWITCH CONTROLLED | Prosthetics & Orthotics | Y | | | |
| L7045 | ELEC HOOK SWITCH/MYOELECTRIC CONTOL PEDIATRIC | Prosthetics & Orthotics | Y | | | |
| L7170 | ELECTRONIC ELBOW HOSMER/EQUAL SWITCH CONTROLLED | Prosthetics & Orthotics | Y | | | |

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|---|---|---|---|---|---|---|
| L7180 | ELEC ELB MICROPRC SEQENTIAL CNTRL ELB AND TERM DEVC | Prosthetics & Orthotics | Y | | | |
| L7181 | ELEC ELB MICROPRC SIMULTAN CNTRL ELB AND TERM DEVC | Prosthetics & Orthotics | Y | | | |
| L7185 | ELEC ELB ADOLES VRITY VILLAGE/EQUAL SWITCH CNTRL | Prosthetics & Orthotics | Y | | | |
| L7186 | ELEC ELB CHILD VRITY VILLAGE/EQUAL SWITCH CNTRL | Prosthetics & Orthotics | Y | | | |
| L7190 | ELEC ELB ADOLES VRITY VILLAGE/ Equal to MYOELEC CNTRL | Prosthetics & Orthotics | Y | | | |
| L7191 | ELEC ELB CHLD VRITY VILL/ Equal to MYOELECTRNICALY CNTRL | Prosthetics & Orthotics | Y | | | |
| L7259 | ELECTRONIC WRIST ROTATOR ANY TYPE | Prosthetics & Orthotics | Y | | | |
| L7406 | ADD TO UPP EXTR USER ADJ MEC | Prosthetics & Orthotics | Y | | | |
| L7499 | UPPER EXTREMITY PROSTHESIS NOS | Prosthetics & Orthotics | Y | | | |
| L8033 | NIPPLE PROSTH CSTM FAB REUSABL ANY MATL ANY T EA | Prosthetics & Orthotics | Y | | | |
| L8039 | BREAST PROSTHESIS NOT OTHERWISE SPECIFIED | Prosthetics & Orthotics | Y | | | |
| L8499 | UNLISTED PROC MISCELLANEOUS PROSTHETIC SERVICES | Prosthetics & Orthotics | Y | | | |
| L8614 | COCHLEAR DEVICE INCLUDES ALL INT AND EXT COMPONENTS | Prosthetics & Orthotics | Y | | | |
| L8678 | ELECTRICAL STIM SUP EXT USE W/I NEUROSTIM PER MO | Prosthetics & Orthotics | Y | | | |
| L8692 | AUDITORY OSSEOINTEGRATED DEV EXT SOUND BODY WORN | Prosthetics & Orthotics | Y | | | |
| L8699 | PROSTHETIC IMPLANT NOT OTHERWISE SPECIFIED | Prosthetics & Orthotics | Y | | | |
| L8701 | PWR UE ROM AST DVC ELB WR HAND 1 DBL UP CUS FAB | Prosthetics & Orthotics | Y | | | |
| L8702 | PWR UE ROM AST DVC ELBO WR H FINGER 1 DBL UP CUS | Prosthetics & Orthotics | Y | | | |
| S1040 | CRANIAL REMOLDING ORTHOTIC PED RIGID CUSTOM FAB | Prosthetics & Orthotics | Y | | | |
| 76965 | US GUIDANCE INTERSTITIAL RADIOELMENT APPLICATION | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77011 | CT GUIDANCE STEREOTACTIC LOCALIZATION | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77014 | CT GUIDANCE RADIATION THERAPY FLDS PLACEMENT | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77261 | THER RAD TX PLNNING SMPL | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77262 | THER RAD TX PLNNING INTRM | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77263 | THER RAD TX PLNNING CPLX | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77280 | THER RAD SIMULAJ-AIDED FIELD SETTING SIMPLE | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |

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| 77285 | THER RAD SIMULAJ-AIDED FIELD SETTING INTERMED | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77290 | THER RAD SIMULAJ-AIDED FIELD SETTING COMPLEX | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77293 | RESPIRATORY MOTION MANAGEMENT SIMULATION | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77295 | 3-D RADIOTHERAPY PLAN DOSE-VOLUME HISTOGRAMS | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77299 | UNLISTD PRCDRE THRPTC RDLGY CLINICAL TX PLANNING | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77300 | BASIC RADIATION DOSIMETRY CALCULATION | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77301 | NTSTY MODUL RADTHX PLN DOSE-VOL HISTOS | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77306 | TELETHX ISODOSE PLN SMPL W/DOSIMETRY CALCULATION | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77307 | TELETHX ISODOSE PLN CPLX W/BASIC DOSIMETRY | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77316 | BRACHYTX ISODOSE PLN SMPL W/DOSIMETRY CAL | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77317 | BRACHYTX ISODOSE PLN INTERMED W/DOSIMETRY CAL | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77318 | BRACHYTX ISODOSE PLN CPLX W/DOSIMETRY CAL | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |

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| 77321 | SPEC TELETHX PORT PLN PARTS HEMIBDY TOT BDY | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77331 | SPEC DOSIM ONLY PRESCRIBED TREATING PHYS | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77332 | TX DEVICES DESIGN AND CONSTRUCTION SIMPLE | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77333 | TX DEVICES DESIGN AND CONSTRUCTION INTERMEDIATE | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77334 | TX DEVICES DESIGN AND CONSTRUCTION COMPLEX | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77336 | CONTINUING MEDICAL PHYSICS CONSLTJ PR WK | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77338 | MLC IMRT DESIGN AND CONSTRUCTION PER IMRT PLAN | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77370 | SPEC MEDICAL RADJ PHYSICS CONSLTJ | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77371 | RADIATION DELIVERY STEREOTACTIC CRANIAL COBALT | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77372 | RADIATION DELIVERY STEREOTACTIC CRANIAL LINEAR | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77373 | STEREOTACTIC BODY RADIATION DELIVERY | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77385 | INTENSITY MODULATED RADIATION TX DLVR SIMPLE | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |

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| 77386 | INTENSITY MODULATED RADIATION TX DLVR COMPLEX | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77387 | GUIDANCE FOR LOCLZJ TARGET VOL FOR RADJ TX DLVR | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77401 | RADIATION TX DELIVERY SUPERFICIAL & ORTHO VOLTA | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77402 | RADIATION TREATMENT DELIVERY 1 MEV PLUS SIMPLE | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77407 | RADIATION TX DELIVERY 1 MEV EQUAL TO GT INTERMEDIATE | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77412 | RADIATION TREATMENT DELIVERY 1 MEV EQ OVER COMPLEX | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77417 | THERAPEUTIC RADIOLOGY PORT IMAGES(S) | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77423 | HI ENRGY NEUTRON RADTN TX DLVR 1 OR GRT ISOCENTER | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77427 | RADIATION TREATMENT MANAGEMENT 5 TREATMENTS | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77431 | RADIATION THERAPY MGMT 1/2 FRACTIONS ONLY | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77432 | STERETCTC RADIATION TX MANAGEMENT CRANIAL LESION | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77435 | STEREOTACTIC BODY RADIATION MANAGEMENT | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |

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| 77470 | SPECIAL TREATMENT PROCEDURE | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77499 | UNLISTED PROCEDURE THRPTC RADIOLOGY TX MGMT | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77520 | PROTON TX DELIVERY SIMPLE W O COMPENSATION | Radiation Therapy & Radio Surgery | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77522 | PROTON TX DELIVERY SIMPLE W COMPENSATION | Radiation Therapy & Radio Surgery | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77523 | PROTON TX DELIVERY INTERMEDIATE | Radiation Therapy & Radio Surgery | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77525 | PROTON TX DELIVERY COMPLEX | Radiation Therapy & Radio Surgery | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77750 | NFS/INSTLJ RADIOELMNT SLN 3 MO FOLLOW-UP CARE | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77761 | INTRACAVITARY RADIATION SOURCE APPLIC SIMPLE | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77762 | INTRACAVITARY RADIATION SOURCE APPLIC INTERMED | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77763 | INTRACAVITARY RADIATION SOURCE APPLIC COMPLEX | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77767 | HDR RDNCL SKN SURF BRACHYTX LES LT 2CM/1 CHAN | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77768 | HDR RDNCLDE SKN SRFCE BRCHYTX LESION >2CM & 2CHAN/MLTPLE LESION | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |

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| 77770 | HDR RDNCL NTRSTL/INTRCAV BRACHYTX 1 CHANNEL | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77771 | HDR RDNCL NTRSTL/INTRCAV BRACHYTX 2-12 CHANNEL | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77772 | HDR RDNCL NTRSTL/INTRCAV BRACHYTX GT 12 CHANNELS | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77778 | INTERSTITIAL RADIATION SOURCE APPLIC COMPLEX | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77789 | SURFACE APPLIC LOW DOSE RATE RADIONUCLIDE SOURCE | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77790 | SUPERVISION HANDLING LOADING RADIATION SOURCE | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| A9513 | LUTETIUM LU 177 DOTATATE THERAPEUTIC 1 MCI | Radiation Therapy & Radio Surgery | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| A9543 | YTTRIUM Y-90 IBRITUMOMAB TIUXETAN TX TO 40 MCI | Radiation Therapy & Radio Surgery | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| A9590 | IODINE I-131 IBOBENGUANE, THERAPEUTIC, I MILLICURE | Radiation Therapy & Radio Surgery | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| A9600 | STRONTIUM SR-89 CHLORID THERAPEUTIC PER MCI | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| A9604 | SAMARIUM SM-153 LEXIDRONAM TX DOSE TO 150 MCI | Radiation Therapy & Radio Surgery | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| A9606 | RADIUM RA-223 DICHLORIDE THERAPEUTIC PER UCI | Radiation Therapy & Radio Surgery | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |

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| G0339 | IMAGE GUID ROBOTIC ACCEL BASE SRS CMPL TX 1 SESS | Radiation Therapy & Radio Surgery | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| G0340 | IMAGE GUID ROBOTIC ACCL SRS FRAC TX LES 2-5 SESS | Radiation Therapy & Radio Surgery | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| G6001 | ULTRASONIC GUID PLACEMENT RADIATION TX FIELDS | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| G6002 | STEREOSCOPIC X-RAY GUID LOCALIZ TRG VOL DEL RT | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| G6003 | RAD TX DEL 2 TX AREA PORT PL OPP PORTS:TO 5 MEV | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| G6004 | RAD TX DEL 1 TX AREA PORT PL OPP PORTS: 6-10 MEV | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| G6005 | RAD TX DEL 1 TX AREA PORT PL OPP PORTS: 11-19 ME | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| G6006 | RAD TX DEL 1 TX AREA PORT PL OPP PORTS: 20 ME OR GRT | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| G6007 | RT DEL 2 SEP AR 3 OR GRT PT 1 TX AR MX BLKS:TO 5 MEV | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| G6008 | RT DEL 2 SEP AR 3 OR GRT PT 1 TX AR MX BLKS:6-10 MEV | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| G6009 | RT DEL 2 SEP AR 3 OR GRT PT 1 TX AR MX BLKS:11-19 MEV | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| G6010 | RT DEL 2 SEP AR 3 OR GRT PT 1 TX AR MX BLKS:20 MEV OR GRT | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |

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| G6011 | RAD TX DEL 3 OR GRT SEP TX AR CSTM BLOCKING; TO 5 MEV | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| G6012 | RAD TX DEL 3 OR GRT SEP TX AR CSTM BLOCKING; 6-10 MEV | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| G6013 | RAD TX DEL 3 OR GRT SEP TX AR CSTM BLOCKING;11-19 MEV | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| G6014 | RAD TX DEL 3 OR GRT SEP TX AR CSTM BLOCKING;20 MEV OR GRT | Radiation Therapy & Radio Surgery | ~ | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| G6015 | INTENSITY MODULATED TX DEL 1 MX FLDS PER TX SESS | Radiation Therapy & Radio Surgery | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| G6016 | COMP-BASED BEAM MOD TX DEL I PLND TX 3 OVER HR SESS | Radiation Therapy & Radio Surgery | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| G6017 | INTRA-FRAC LOC AND TRACKING TARGET PT M EA FRAC TX | Radiation Therapy & Radio Surgery | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 95805 | MLT SLEEP LATENCY MAINT OF WAKEFULNESS TSTG | Sleep Studies | Y | | | |
| 95807 | SLEEP STD REC VNTJ RESPIR ECG HRT RATE AND O2 ATTN | Sleep Studies | Y | | | |
| 95808 | POLYSOM ANY AGE SLEEP STAGE 1-3 ADDL PARAM ATTND | Sleep Studies | Y | | | |
| 95810 | POLYSOM 6 OR GRT YRS SLEEP 4 OR GRT ADDL PARAM ATTND | Sleep Studies | Y | | | |
| 95811 | POLYSOM 6 OR GRT YRS SLEEP W CPAP 4 OR GRT ADDL PARAM ATT | Sleep Studies | Y | | | |
| 32850 | DONOR PNEUMONECTOMY(S), INCL COLD PRESERV, FROM CADAVER DONOR | Transplants/Gene Therapy | Y | | | |
| 32851 | LUNG TRANSPL, SINGLE, W O CARDIOPULM BYPASS | Transplants/Gene Therapy | Y | | | |
| 32852 | LUNG TRANSPL, SINGLE, W CARDIOPULM BYPASS | Transplants/Gene Therapy | Y | | | |
| 32853 | LUNG TRANSPLANT 2 W O CARDIOPULMONARY BYPASS | Transplants/Gene Therapy | Y | | | |
| 32854 | LUNG TRANSPLANT 2 W CARDIOPULMONARY BYPASS | Transplants/Gene Therapy | Y | | | |
| 32855 | BKBENCH PREPJ CADAVER DONOR LUNG ALLOGRAFT UNI | Transplants/Gene Therapy | Y | | | |
| 32856 | BKBENCH PREPJ CADAVER DONOR LUNG ALLOGRAFT BI | Transplants/Gene Therapy | Y | | | |
| 33929 | REMOVAL TOTAL RPLCMT HEART SYS FOR HEART TRNSPL | Transplants/Gene Therapy | Y | | | |
| 33930 | DONOR CARDIECTOMY - PNEUMONECTOMY | Transplants/Gene Therapy | Y | | | |
| 33933 | BKBENCH PREPJ CADAVER DONOR HEART LUNG ALLOGRAFT | Transplants/Gene Therapy | Y | | | |
| 33935 | HEART-LUNG TRNSPL W/RECIPIENT CARDIECTOMY-PNUMEC | Transplants/Gene Therapy | Y | | | |
| 33940 | DONOR CARDIECTOMY | Transplants/Gene Therapy | Y | | | |
| 33944 | BKBENCH PREPJ CADAVER DONOR HEART ALLOGRAFT | Transplants/Gene Therapy | Y | | | |
| 33945 | HEART TRANSPLANT W/WO RECIPIENT CARDIECTOMY | Transplants/Gene Therapy | Y | | | |
| 33995 | INSJ PERQ VAD W/RS AND I R HEART VENOUS ACCESS ONLY | Transplants/Gene Therapy | Y | | | |
| 38204 | MGMT RCP HEMATOP PROGENITOR CELL DONOR AND ACQUISJ | Transplants/Gene Therapy | Y | | | |

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|---|---|---|---|---|---|---|
| 38205 | BLD-DRV HEMATOP PROGEN CELL HRVG TRNSPLJ ALGNC | Transplants/Gene Therapy | Y | | | |
| 38206 | BLD-DRV HEMATOPTC PROGEN CELL HRVSTG TRNSPL AUTO | Transplants/Gene Therapy | Y | | | |
| 38207 | TRNSPL PREPJ HEMATOP PROGEN CELLS CRYOPRSRV STOR | Transplants/Gene Therapy | Y | | | |
| 38208 | TRNSPL PREP HEMATOP PROGEN THAW PREV HRV PER DNR | Transplants/Gene Therapy | Y | | | |
| 38209 | TRNSP PREP HMATOP PROG THAW PREV HRV WSH PER DNR | Transplants/Gene Therapy | Y | | | |
| 38210 | TRNSPL PREPJ HEMATOP PROGEN DEPLJ IN HRV T-CELL | Transplants/Gene Therapy | Y | | | |
| 38211 | TRNSPL PREPJ HEMATOP PROGEN TUM CELL DEPLJ | Transplants/Gene Therapy | Y | | | |
| 38212 | TRNSPL PREPJ HEMATOP PROGEN RED BLD CELL RMVL | Transplants/Gene Therapy | Y | | | |
| 38213 | TRNSPL PREPJ HEMATOP PROGEN PLTLT DEPLJ | Transplants/Gene Therapy | Y | | | |
| 38214 | TRNSPL PREPJ HEMATOP PROGEN PLSM VOL DEPLJ | Transplants/Gene Therapy | Y | | | |
| 38215 | TRNSPL PREPJ HEMATOP PROGEN CONCENTRATION PLSM | Transplants/Gene Therapy | Y | | | |
| 38225 | CAR-T THERAPY HRVG BLD DRV T LMPHCYT PR DAY | Transplants/Gene Therapy | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥ 18 with cancer diagnosis, direct request to Evolent. For Pediatrics and non cancer diagnosis direct request to the healthplan. | Y |
| 38226 | CAR-T THERAPY PREPJ BLD DRV T LMPHCYT F/TRNS | Transplants/Gene Therapy | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥ 18 with cancer diagnosis, direct request to Evolent. For Pediatrics and non cancer diagnosis direct request to the healthplan. | Y |
| 38227 | CAR-T THERAPY RECEIPT and PREP CAR-T CELLS F/ADMN | Transplants/Gene Therapy | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥ 18 with cancer diagnosis, direct request to Evolent. For Pediatrics and non cancer diagnosis direct request to the healthplan. | Y |
| 38228 | CAR-T THERAPY AUTOLOGOUS CELL ADMINISTRATION | Transplants/Gene Therapy | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥ 18 with cancer diagnosis, direct request to Evolent. For Pediatrics and non cancer diagnosis direct request to the healthplan. | Y |
| 38230 | BONE MARROW HARVEST TRANSPLANTATION ALLOGENEIC | Transplants/Gene Therapy | Y | | | |
| 38232 | BONE MARROW HARVEST TRANSPLANTATION AUTOLOGOUS | Transplants/Gene Therapy | Y | | | |
| 38240 | TRNSPLJ ALLOGENEIC HEMATOPOIETIC CELLS PER DONOR | Transplants/Gene Therapy | Y | | | |
| 38241 | TRNSPLJ AUTOLOGOUS HEMATOPOIETIC CELLS PER DONOR | Transplants/Gene Therapy | Y | | | |
| 38242 | ALLOGENEIC LYMPHOCYTE INFUSIONS | Transplants/Gene Therapy | Y | | | |
| 38243 | TRNSPLJ HEMATOPOIETIC CELL BOOST | Transplants/Gene Therapy | Y | | | |
| 44132 | DONOR ENTERECTOMY OPEN CADAVER DONOR | Transplants/Gene Therapy | Y | | | |
| 44133 | DONOR ENTERECTOMY OPEN LIVING DONOR | Transplants/Gene Therapy | Y | | | |
| 44135 | INTESTINAL ALLOTRANSPLANTATION; CADAVER DONOR | Transplants/Gene Therapy | Y | | | |
| 44136 | INTESTINAL ALLOTRANSPLANTATION; LIVING DONOR | Transplants/Gene Therapy | Y | | | |
| 44137 | RMVL TRNSPLED INTESTINAL ALLOGRAFT COMPL | Transplants/Gene Therapy | Y | | | |
| 44715 | BKBENCH PREP CADAVER LIVING DONOR INTESTINE | Transplants/Gene Therapy | Y | | | |
| 44720 | BKBENCH RCNSTJ INT ALGRFT VEN ANAST EA | Transplants/Gene Therapy | Y | | | |
| 44721 | BKBENCH RCNSTJ INT ALGRFT ARTL ANAST EA | Transplants/Gene Therapy | Y | | | |
| 47133 | DONOR HEPATECTOMY CADAVER DONOR | Transplants/Gene Therapy | Y | | | |
| 47135 | LVR ALTRNSPLJ ORTHOTOPIC PRTL WHL DON ANY AGE | Transplants/Gene Therapy | Y | | | |
| 47140 | DONOR HEPATECTOMY LIVING DONOR SEG II AND III | Transplants/Gene Therapy | Y | | | |
| 47141 | DONOR HEPATECTOMY LIVING DONOR SEG II III AND IV | Transplants/Gene Therapy | Y | | | |
| 47142 | DONOR HEPATECTOMY LIVING DONOR SEG V VI VII AND VI | Transplants/Gene Therapy | Y | | | |
| 47143 | BKBENCH PREP CADAVER DONOR | Transplants/Gene Therapy | Y | | | |
| 47144 | BKBENCH PREPJ CADAVER WHOLE LIVER GRF I AND IV VII | Transplants/Gene Therapy | Y | | | |
| 47145 | BKBENCH PREPN CADAVER DONOR WHL LVR GRF I AND V VI | Transplants/Gene Therapy | Y | | | |
| 47146 | BKBENCH RCNSTJ LVR GRF VENOUS ANAST EA | Transplants/Gene Therapy | Y | | | |

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| 47147 | BKBENCH RCNSTJ LVR GRF ARTL ANAST EA | Transplants/Gene Therapy | Y | | | |
| 48160 | PANCREATECTOMY W TRNSPLJ PANCREAS ISLET CELLS | Transplants/Gene Therapy | Y | | | |
| 48550 | DONOR PANCREATECTOMY DUODENAL SGM TRANSPLANT | Transplants/Gene Therapy | Y | | | |
| 48551 | BKBENCH PREPJ CADAVER DONOR PANCREAS ALLOGRAFT | Transplants/Gene Therapy | Y | | | |
| 48552 | BKBENCH RCNSTN CDVR PNCRS ALGRFT VEN ANAST EA | Transplants/Gene Therapy | Y | | | |
| 48554 | TRANSPLANTATION PANCREATIC ALLOGRAFT | Transplants/Gene Therapy | Y | | | |
| 48556 | RMVL TRANSPLANTED PANCREATIC ALLOGRAFT | Transplants/Gene Therapy | Y | | | |
| 50300 | DONOR NEPHRECTOMY CADAVER DONOR UNI BILATERAL | Transplants/Gene Therapy | Y | | | |
| 50320 | DONOR NEPHRECTOMY OPEN LIVING DONOR | Transplants/Gene Therapy | Y | | | |
| 50323 | BKBENCH PREPJ CADAVER DONOR RENAL ALLOGRAFT | Transplants/Gene Therapy | Y | | | |
| 50325 | BKBENCH PREPJ LIVING RENAL DONOR ALLOGRAFT | Transplants/Gene Therapy | Y | | | |
| 50327 | BKBENCH RCNSTJ RENAL ALGRFT VENOUS ANAST EA | Transplants/Gene Therapy | Y | | | |
| 50328 | BKBENCH RCNSTJ RENAL ALLOGRAFT ARTERIAL ANAST EA | Transplants/Gene Therapy | Y | | | |
| 50329 | BKBENCH RCNSTJ ALGRFT URETERAL ANAST EA | Transplants/Gene Therapy | Y | | | |
| 50340 | RECIPIENT NEPHRECTOMY SEPARATE PROCEDURE | Transplants/Gene Therapy | Y | | | |
| 50360 | RENAL ALTRNSPLJ IMPLTJ GRF W O RCP NEPHRECTOMY | Transplants/Gene Therapy | Y | | | |
| 50365 | RENAL ALTRNSPLJ IMPLTJ GRF W RCP NEPHRECTOMY | Transplants/Gene Therapy | Y | | | |
| 50370 | RMVL TRNSPLED RENAL ALLOGRAFT | Transplants/Gene Therapy | Y | | | |
| 50380 | RENAL AUTOTRNSPLJ REIMPLANTATION KIDNEY | Transplants/Gene Therapy | Y | | | |
| 81560 | TRNSPLJ PED LVR AND BWL MES CD154 PLUS T CLL WHL PRPH BLD | Transplants/Gene Therapy | Y | | | |
| 0584T | PERCUTANEOUS ISLET CELL TRANSPLANT | Transplants/Gene Therapy | Y | | | |
| 0585T | LAPAROSCOPIC ISLET CELL TRANSPLANT | Transplants/Gene Therapy | Y | | | |
| 0586T | OPEN ISLET CELL TRANSPLANT | Transplants/Gene Therapy | Y | | | |
| J1411 | INJ, HEMGENIX, PER TX DOSE | Transplants/Gene Therapy | NC | | | |
| J1412 | INJECTION VALOCTOCOGENE ROXAPARVOVEC-RVOX PER ML | Transplants/Gene Therapy | NC | | | |
| J1413 | INJ DELANDISTROGENE MOXEPARVOVEC-ROKL PER THR D | Transplants/Gene Therapy | NC | | | |
| J1414 | INJ, FIDANACOGENE ELAPARVOVECDZKT, PER THERAPEUTIC DOSE | Transplants/Gene Therapy | NC | | | |
| J3391 | INJ, ATIDARSAGENE AUTOTEMCEL, PER TREATMENT | Transplants/Gene Therapy | NC | | | |
| J3392 | INJ, EXAGAMGLOGENE AUTOTEMCEL, PER TREATMENT | Transplants/Gene Therapy | NC | | | |
| J3393 | INJ, BETIBEGLOGENE AUTOTEMCEL, PER TREATMENT | Transplants/Gene Therapy | NC | | | |
| J3394 | INJ, LOVOTIBEGLOGENE AUTOTEMCEL, PER TREATMENT | Transplants/Gene Therapy | NC | | | |
| J3398 | INJECTION VORETIGENE NEPARVOVEC-RZYL 1 B VEC G | Transplants/Gene Therapy | NC | | | |
| J3399 | INJECTION, ONASEMNOGENE ABEPARVOVEC, PER TX, UP TO 5X10 | Transplants/Gene Therapy | NC | | | |
| J3401 | BEREMAGENE GEPERPAVEC-SVDT, PER 0.1 ML | Transplants/Gene Therapy | NC | | | |
| J3402 | INJ, REMESTEMCEL-L-RKND, PER THERAPEUTIC DOSE | Transplants/Gene Therapy | Y | | | |
| J9029 | IVES INSTAL NADOFARAGN FIRADENOVC-VNCG PER THR D | Transplants/Gene Therapy | NC | | | |
| Q2041 | KTE-C19 TO 200 M A ANTI-CD19 CAR POS T CE P TD | Transplants/Gene Therapy | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥ 18 with cancer diagnosis, direct request to Evolent. For Pediatrics and non cancer diagnosis direct request to the healthplan. | Y |
| Q2042 | TISAGENLECLEUCEL TO 600 M CAR-POS VI T CE PER TD | Transplants/Gene Therapy | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥ 18 with cancer diagnosis, direct request to Evolent. For Pediatrics and non cancer diagnosis direct request to the healthplan. | Y |
| Q2043 | SIPULEUCEL-T AUTO CD54 PLUS | Transplants/Gene Therapy | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥ 18 with cancer diagnosis, direct request to Evolent. For Pediatrics and non cancer diagnosis direct request to the healthplan. | Y |

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| Q2053 | BREXUCABTAGENE CAR POST | Transplants/Gene Therapy | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥ 18 with cancer diagnosis, direct request to Evolent. For Pediatrics and non cancer diagnosis direct request to the healthplan. | Y |
| Q2054 | LM GT OR EQUAL TO 110 MIL AUTOL ANTI-CD19 CAR-POS VIABL T | Transplants/Gene Therapy | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥ 18 with cancer diagnosis, direct request to Evolent. For Pediatrics and non cancer diagnosis direct request to the healthplan. | Y |
| Q2055 | IDECABTAGENE VICL 460MIL AUTO BCMA CAR PLUS T LEUKAPH | Transplants/Gene Therapy | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥ 18 with cancer diagnosis, direct request to Evolent. For Pediatrics and non cancer diagnosis direct request to the healthplan. | Y |
| Q2056 | CILTACABTAGENE AUTOLEUCEL TO 100 M BCMA PER TX D | Transplants/Gene Therapy | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥ 18 with cancer diagnosis, direct request to Evolent. For Pediatrics and non cancer diagnosis direct request to the healthplan. | Y |
| Q2057 | AFAMITRESGENE AUTOLEUCEL, INCLDNG LEUKAPHERESIS & DOSE PRPRTN PRCDRS, PER THRPTC DOSE | Transplants/Gene Therapy | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥ 18 with cancer diagnosis, direct request to Evolent. For Pediatrics and non cancer diagnosis direct request to the healthplan. | Y |
| Q2058 | OBECABTAGENE CAR POS T | Transplants/Gene Therapy | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults > 18 with cancer diagnosis, direct request to Evolent. For Pediatrics and non cancer diagnosis direct request to the healthplan. | Y |
| S2053 | TRANSPLANTATION SMALL INTESTINE AND LIVER ALLOGRAFTS | Transplants/Gene Therapy | Y | | | |
| S2054 | TRANSPLANTATION OF MULTIVISCERAL ORGANS | Transplants/Gene Therapy | Y | | | |
| S2055 | HARVEST DONOR MX-VISCERAL ORGAN; CADVER DONOR | Transplants/Gene Therapy | Y | | | |
| S2060 | LOBAR LUNG TRANSPLANTATION | Transplants/Gene Therapy | Y | | | |
| S2061 | DONOR LOBECTOMY FOR TRANSPLANTATION LIVING DONOR | Transplants/Gene Therapy | Y | | | |
| S2065 | SIMULTANEOUS PANCREAS KIDNEY TRANSPLANTATION | Transplants/Gene Therapy | Y | | | |
| S2107 | ADOPTIVE IMMUNOTHERAPY PER COURSE OF TREATMENT | Transplants/Gene Therapy | Y | | | |
| S2140 | CORD BLOOD HARVESTING TRANSPLANTATION ALLOGENEIC | Transplants/Gene Therapy | Y | | | |
| S2142 | CORD BLD-DERIVED STEM-CELL TPLNT ALLOGENEIC | Transplants/Gene Therapy | Y | | | |
| S2150 | BN MARROW BLD DERIVD STEM CELLS HARV TPLNT AND COMP | Transplants/Gene Therapy | Y | | | |
| S2152 | SOLID ORGAN; TRANSPLANTATION AND RELATED COMP | Transplants/Gene Therapy | Y | | | |
| A0160 | NONEMERG TRNSPRT: PER MILE-CASE SOCIAL WORKER | Transportation | | | | |
| A0380 | BLS MILEAGE | Transportation | | | | |
| A0390 | ALS MILEAGE | Transportation | | | | |
| A0424 | EXTRA AMBULANCE ATTENDANT GROUND OR AIR ; | Transportation | | | | |
| A0425 | GROUND MILEAGE PER STATUTE MILE | Transportation | | | | |
| A0426 | AMB SERVICE ALS NONEMERGENCY TRANSPORT LEVEL 1 | Transportation | | | | |
| A0428 | AMBULANCE SERVICE BLS NONEMERGENCY TRANSPORT | Transportation | | | | |
| A0430 | AMB SERVICE CONVNTION AIR SRVC TRANSPORT 1 WAY FIXED WING | Transportation | | | | |
| A0431 | AMB SERVICE CONVNTION AIR SRVC TRANSPORT 1 WAY ROTARY WING | Transportation | | | | |
| A0435 | FIXED WING AIR MILEAGE PER STATUTE MILE | Transportation | | | | |
| A0436 | ROTARY WING AIR MILEAGE PER STATUTE MILE | Transportation | | | | |
| 17999 | UNLISTED PX SKIN MUC MEMBRANE AND SUBQ TISSUE | Unlisted/Miscellaneous | Y | | | |
| 19499 | UNLISTED PROCEDURE BREAST | Unlisted/Miscellaneous | Y | | | |

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|---|---|---|---|---|---|---|
| 21089 | UNLISTED MAXILLOFACIAL PROSTHETIC PROCEDURE | Unlisted/Miscellaneous | Y | | | |
| 21299 | UNLISTED CRANIOFACIAL AND MAXILLOFACIAL PROCEDURE | Unlisted/Miscellaneous | Y | | | |
| 22899 | UNLISTED PROCEDURE SPINE | Unlisted/Miscellaneous | Y | | | |
| 22999 | UNLISTED PX ABDOMEN MUSCULOSKELETAL SYSTEM | Unlisted/Miscellaneous | Y | | | |
| 23929 | UNLISTED PROCEDURE SHOULDER | Unlisted/Miscellaneous | Y | | | |
| 26989 | UNLISTED PROCEDURE HANDS FINGERS | Unlisted/Miscellaneous | Y | | | |
| 27299 | UNLISTED PROCEDURE PELVIS HIP JOINT | Unlisted/Miscellaneous | Y | | | |
| 29999 | UNLISTED PROCEDURE ARTHROSCOPY | Unlisted/Miscellaneous | Y | | | |
| 30999 | UNLISTED PROCEDURE NOSE | Unlisted/Miscellaneous | Y | | | |
| 37501 | UNLISTED VASCULAR ENDOSCOPY PROCEDURE | Unlisted/Miscellaneous | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). Send to Evolent for members ≥18. Send to healthplan for members under 18. | |
| 37799 | UNLISTED PROCEDURE VASCULAR SURGERY | Unlisted/Miscellaneous | Y | | | |
| 38999 | UNLISTED PROCEDURE HEMIC OR LYMPHATIC SYSTEM | Unlisted/Miscellaneous | Y | | | |
| 39499 | UNLISTED PROCEDURE MEDIASTINUM | Unlisted/Miscellaneous | Y | | | |
| 39599 | UNLISTED PROCEDURE DIAPHRAGM | Unlisted/Miscellaneous | Y | | | |
| 40799 | UNLISTED PROCEDURE LIPS | Unlisted/Miscellaneous | Y | | | |
| 41599 | UNLISTED PROCEDURE TONGUE FLOOR MOUTH | Unlisted/Miscellaneous | Y | | | |
| 42299 | UNLISTED PROCEDURE PALATE UVULA | Unlisted/Miscellaneous | Y | | | |
| 43499 | UNLISTED PROCEDURE ESOPHAGUS | Unlisted/Miscellaneous | Y | | | |
| 43659 | UNLISTED LAPAROSCOPIC PROCEDURE STOMACH | Unlisted/Miscellaneous | Y | | | |
| 43999 | UNLISTED PROCEDURE STOMACH | Unlisted/Miscellaneous | Y | | | |
| 45399 | UNLISTED PROCEDURE COLON | Unlisted/Miscellaneous | Y | | | |
| 47379 | UNLIS LAPAROSCOPIC PROCEDURE LIVER | Unlisted/Miscellaneous | Y | | | |
| 47999 | UNLISTED PROCEDURE BILIARY TRACT | Unlisted/Miscellaneous | Y | | | |
| 49999 | UNLISTD PROCEDURE ABDOMEN PERITONEUM & OMENTUM | Unlisted/Miscellaneous | Y | | | |
| 54699 | UNLISTED LAPAROSCOPY PROCEDURE TESTIS | Unlisted/Miscellaneous | Y | | | |
| 55559 | UNLISTED LAPROSCOPY PROCEDURE SPERMATIC CORD | Unlisted/Miscellaneous | Y | | | |
| 55899 | UNLISTED PROCEDURE MALE GENITAL SYSTEM | Unlisted/Miscellaneous | Y | | | |
| 58578 | UNLISTED LAPAROSCOPY PROCEDURE UTERUS | Unlisted/Miscellaneous | Y | | | |
| 58679 | UNLISTED LAPAROSCOPY PROCEDURE OVIDUCT OVARY | Unlisted/Miscellaneous | Y | | | |
| 58999 | UNLISTED PX FEMALE GENITAL SYSTEM NONOBSTETRICAL | Unlisted/Miscellaneous | Y | | | |
| 60699 | UNLISTED PROCEDURE ENDOCRINE SYSTEM | Unlisted/Miscellaneous | Y | | | |
| 64999 | UNLISTED PROCEDURE NERVOUS SYSTEM | Unlisted/Miscellaneous | Y | | | |
| 67299 | UNLISTED PROCEDURE POSTERIOR SEGMENT | Unlisted/Miscellaneous | Y | | | |
| 68899 | UNLISTED PROCEDURE LACRIMAL SYSTEM | Unlisted/Miscellaneous | Y | | | |
| 77399 | UNLIS MEDICAL RADJ DOSIM TX DEV SPEC SVCS | Unlisted/Miscellaneous | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 77799 | UNLISTED PROCEDURE CLINICAL BRACHYTHERAPY | Unlisted/Miscellaneous | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | Y |
| 87797 | IADNA NOS DIRECT PROBE TQ EACH ORGANISM | Unlisted/Miscellaneous | Y | | | |
| 87798 | IADNA NOS AMPLIFIED PROBE TQ EACH ORGANISM | Unlisted/Miscellaneous | Y | | | |
| 87799 | IADNA NOS QUANTIFICATION EACH ORGANISM | Unlisted/Miscellaneous | Y | | | |
| 87899 | IAADIADOO NOT OTHERWISE SPECIFIED | Unlisted/Miscellaneous | Y | | | |
| 88299 | UNLISTED CYTOGENETIC STUDY | Unlisted/Miscellaneous | Y | | | |
| 93799 | UNLISTED CARDIOVASCULAR SERVICE PROCEDURE | Unlisted/Miscellaneous | Y | | | |

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|---|---|---|---|---|---|---|
| 95999 | UNLIS NEUROLOGICAL NEUROMUSCULAR DX PX | Unlisted/Miscellaneous | Y | | | |
| 96549 | UNLISTED CHEMOTHERAPY PROCEDURE | Unlisted/Miscellaneous | Y | | | |
| 97039 | UNLIST MODALITY SPEC TYPE AND TIME CONSTANT ATTEND | Unlisted/Miscellaneous | Y | | | |
| 97139 | UNLISTED THERAPEUTIC PROCEDURE SPECIFY | Unlisted/Miscellaneous | Y | | For PT/OT, PA required after initial evaluation + 12 visits/year (12 visits allowed for each discipline). | |
| 97799 | UNLISTED PHYSICAL MEDICINE/REHAB SERVICE/PROC | Unlisted/Miscellaneous | Y | | | |
| 99499 | UNLISTED EVALUATION AND MANAGEMENT SERVICE | Unlisted/Miscellaneous | Y | | | |
| 99600 | UNLISTED HOME VISIT SERVICE PROCEDURE | Unlisted/Miscellaneous | Y | | | |
| 0708T | INTRADERMAL CANCER IMMNTX PREP AND 1ST INJECTION | Unlisted/Miscellaneous | Y | | | |
| 0709T | INTRADERMAL CANCER IMMNTX EACH ADDL INJECTION | Unlisted/Miscellaneous | Y | | | |
| A0999 | UNLISTED AMBULANCE SERVICE | Unlisted/Miscellaneous | Y | | | |
| A4649 | SURGICAL SUPPLY; MISCELLANEOUS | Unlisted/Miscellaneous | Y | | | |
| A6262 | WOUND FILLER DRY FORM PER G NOT OTHERWISE SPEC | Unlisted/Miscellaneous | Y | | | |
| A9291 | PRESCRIPTION DIGITAL BT FDA CLEARED PER CRS TX | Unlisted/Miscellaneous | Y | | | |
| A9699 | RADIOPHARMACEUTICAL THERAPEUTIC NOC | Unlisted/Miscellaneous | Y | Y~ | ~Applies only to plans partnered with Evolent (see healthplan scope inclusion list in columns to the right). For Adults ≥18 with cancer diagnosis, direct request to Evolent. For Inpatient, non cancer diagnosis, and pediatrics send request to healthplan. | |
| A9900 | DME SUP ACCESS SRV-COMPON OTH HCPCS | Unlisted/Miscellaneous | Y | | | |
| A9999 | MISCELLANEOUS DME SUPPLY OR ACCESSORY NOS | Unlisted/Miscellaneous | Y | | | |
| B9998 | NOC FOR ENTERAL SUPPLIES | Unlisted/Miscellaneous | Y | | | |
| E0769 | ESTIM ELECTROMAGNETIC WOUND TREATMENT DEVC NOC | Unlisted/Miscellaneous | Y | | | |
| E0770 | FES TRANSQ STIM NERV AND MUSC GRP CMPL SYS NOS | Unlisted/Miscellaneous | Y | | | |
| E1399 | DURABLE MEDICAL EQUIPMENT MISCELLANEOUS | Unlisted/Miscellaneous | Y | | | |
| G2082 | OFF/OTH OP E and M EST PT PROV 56 MG ESKETAMINE N SA | Unlisted/Miscellaneous | Y | | | |
| G2083 | OFF/OTH OP E and M EST PT PROV GT 56 MG ESKETAMINE N SA | Unlisted/Miscellaneous | Y | | | |
| J7599 | IMMUNOSUPPRESSIVE DRUG NOT OTHERWISE CLASSIFIED | Unlisted/Miscellaneous | Y | | | |
| J7699 | NOC DRUGS INHALATION SOLUTION ADMINED THRU DME | Unlisted/Miscellaneous | Y | | | |
| J7799 | NOC RX OTH THAN INHALATION RX ADMINED THRU DME | Unlisted/Miscellaneous | Y | | | |
| J8597 | ANTIEMETIC DRUG ORAL NOT OTHERWISE SPECIFIED | Unlisted/Miscellaneous | Y | | | |
| Q0508 | MISC SUPPLY OR ACCESSORY USE WITH IMPLANTED VAD | Unlisted/Miscellaneous | Y | | | |
| Q4082 | DRUG OR BIOLOGICAL NOC PART B DRUG CAP | Unlisted/Miscellaneous | Y | | | |
| Q4100 | SKIN SUBSTITUTE NOT OTHERWISE SPECIFIED | Unlisted/Miscellaneous | Y | | | |
| S0590 | INTEGRAL LENS SERVICE MISC SERVICES REPORTED SEP | Unlisted/Miscellaneous | Y | | | |
| S9110 | TELEMONITORING PT HOME ALL NEC EQUIP; PER MONTH | Unlisted/Miscellaneous | Y | | | |
| S9432 | MEDICAL FOODS FOR NONINBORN ERRORS OF METABOLISM | Unlisted/Miscellaneous | Y | | | |
| T5999 | SUPPLY NOT OTHERWISE SPECIFIED | Unlisted/Miscellaneous | Y | | | |
| V2524 | CONTACT LENS HPI SPH PC ADDITIVE PER LENS | Unlisted/Miscellaneous | Y | | | |
| V2799 | VISION ITEM OR SERVICE MISCELLANEOUS | Unlisted/Miscellaneous | Y | | | |
| V5298 | HEARING AID NOT OTHERWISE CLASSIFIED | Unlisted/Miscellaneous | Y | | | |
| V5299 | HEARING SERVICE MISCELLANEOUS | Unlisted/Miscellaneous | Y | | | |