MEDICAL POLICY

Medical Policy Title	**Pancreas Transplant: (Pancreas Transplant Alone, Pancreas Transplant after Kidney Transplant, Simultaneous Pancreas Kidney Transplant): Islet Cell Transplant**
Policy Number	**07.02.01**
Current Effective Date	**March 19, 2026**
Next Review Date	**March 2027**

Our medical policies are guides to evaluate technologies or services for medical necessity. Criteria are established through the assessment of evidence based, peer-reviewed scientific literature, and national professional guidelines. Federal and state law(s), regulatory mandates and the member's subscriber contract language are considered first in the determination of a covered service.
(Link to Product Disclaimer)

POLICY STATEMENT(S)

Pancreatic Transplant Alone (PTA)

I. Pancreas transplant alone (PTA) is considered **medically appropriate** for candidates who meet **ALL** the following indications:

   A. Insulin dependent diabetes mellitus (IDDM) that is difficult to manage (e.g., labile);

   B. A history of frequent, acute, and severe metabolic complications (e.g., hypoglycemia, hyperglycemia, ketoacidosis) requiring medical attention;

   C. Consistent failure of insulin-based management to prevent acute complications; **and**

   D. Do not have advanced kidney disease (stage IV or V).

Pancreas After Kidney Transplant (PAK)

II. Pancreas transplant after kidney transplant (PAK) is considered **medically appropriate** for candidates who meet **ALL** the following indications:

   A. Diagnosis of IDDM;

   B. Have had a previous successful kidney transplantation for uremia or kidney failure;

   C. A history of frequent, acute, and severe metabolic complications (e.g., hypoglycemia, hyperglycemia, ketoacidosis) requiring medical attention;

   D. Consistent failure of insulin-based management to prevent acute complications; **and**

   E. Does not have advanced kidney disease (stage IV or stage V).

Simultaneous Pancreas-Kidney Transplantation (SPK)

III. Simultaneous transplant of the pancreas is considered **medically appropriate** for candidates who meet **ALL** the following indications:

   A. For uremic IDDM individuals who have no immediate life-threatening conditions;

   B. A history of frequent, acute, and severe metabolic complications (e.g., hypoglycemia,

hyperglycemia, ketoacidosis) requiring medical attention; **and**

C. Consistent failure of insulin-based management to prevent acute complications.

IV. A second pancreas transplant after a failed primary transplant is considered **medically appropriate** in individuals who still meet transplant criteria.

V. Autologous islet cell transplantation is considered **medically appropriate** as an adjunct to a total or near-total pancreatectomy in individuals with chronic pancreatitis.

VI. Allogeneic pancreatic islet cell transplantation of a U.S. Food & Drug Administration (FDA) approved cellular therapy product i.e., donislecel-jujn, (Lantidra) is considered **investigational** for the treatment of type 1 diabetes.

VII. Recipient Selection Guidelines

A. Each individual considered for pancreas transplantation will have an evaluation completed by the transplant center for potential difficulties that would complicate and diminish the success of transplantation. Consideration will be given to the individual's risk of death without transplantation, along with the presence and severity of potential contraindications to transplantation. Candidates considered for transplant must be psychologically stable, demonstrate motivation and compliance, and have no ongoing problems with drug or alcohol abuse.

B. The following conditions are absolute contraindications to PTA, PAK, SPK and islet cell transplantation:

1. Presence of malignancy (other than non-melanomatous skin cancers), unless malignancy has been completely resected or unless (upon medical review) it is determined that malignancy has been treated, there is a small likelihood of recurrence, and acceptable future risks;
2. Ongoing or recurring infections that are not effectively treated;
3. Serious cardiac or other insufficiencies and an inability to tolerate transplant surgery;
4. Demonstrated non-compliance, which places the organ at risk by not adhering to medical recommendations;

C. Pancreas transplant is considered a relative contraindication in human immunodeficiency virus (HIV) positive individuals, unless **ALL** of the following criteria are met:

1. CD4 count is greater than 200 cells/mm3;
2. HIV-1 ribonucleic acid RNA is undetectable;
3. Stable anti-retroviral therapy for greater than three (3) months;
4. No other complications from AIDS (e.g., opportunistic infection, including aspergillus, tuberculosis, coccidioidomycosis; resistant fungal infections, Kaposi's sarcoma, or other neoplasm);

5. Meets all other criteria for transplantation.

RELATED POLICIES

Corporate Medical Policy

07.02.04 Kidney Transplantation

11.01.03 Experimental or Investigational Services

Pharmacy Policy

115 Lantidra

POLICY GUIDELINE(S)

I. Segmental Living Donation Guidelines

A. Any person who gives consent to be a live organ donor should be competent, willing to donate, free from coercion, medically and psychologically suitable, fully informed of the risks and benefits as a donor, and fully informed of the risks, benefits, and alternative treatment available to the recipient. The benefits to both donor and recipient must outweigh the risks associated with the donation and transplantation of the living donor organ.

B. Prior authorization is contract dependent. Approval for all transplants, including arrangements with an approved transplant center, may be required.

C. The benefits of glycemic control must be weighed against the risks associated with transplant surgery and subsequent chronic immunosuppression. The individual must demonstrate motivation and ability for self-care and have failed to obtain diabetic control.

D. A pre-emptive cadaveric or living kidney transplant should be carefully considered when the measured (actual urinary collection) creatinine clearance level or calculated glomerular filtration rate (GFR) (or other reliable formula) is less than 30 ml/min and with a rapid rate of decline.

II. Pre-transplant evaluation documentation must include the following clinical information, and, if testing cannot be performed, the rationale for not performing the testing must be included in the documentation:

A. Clinical Evaluation:

1. Confirmation of diagnosis;
2. Identification of comorbidities;
3. Current assessment of co-morbidities;
4. Management of co-morbidities; **and**
5. Consult notes (if applicable);

B. Psycho-Social Evaluation:

1. Identification of stressors (e.g., family support, noncompliance issues, motivational issues, alcohol, or smoking/substance abuse).

C. Performance Status:

1. Karnofsky performance score;
2. Palliative Performance Scale (PPS) score;
3. Eastern Cooperative Oncology Group (ECOG) performance status; **or**
4. Lansky Play-Performance Scale (for age 1 to 16 years).

D. Oral Health Evaluation;

E. Lab Tests:

1. CBC, metabolic profile;
2. Serologies: CMV; Hepatitis B and C; **and**
3. HIV Testing.

F. Cardiac Assessment:

1. 12 Lead EKG;
2. Stress test (exercise, nuclear, or dobutamine); **and**
3. Echo or Muga Scan.

G. Pulmonary Assessment:

1. Chest x-ray;
2. Pulmonary function tests (PFTs); for high-risk of respiratory failure (COPD, emphysema, alpha-1 antitrypsin deficiency, hepatopulmonary syndrome, or significant smoking history).

H. Age-Appropriate Screening Tests: Please refer to the U.S Preventive Services Task Force (USPSTF) [Internet] for a list of age-appropriate screening guidelines (e.g., colorectal cancer screening, cervical cancer screening for guidance). [accessed 2025 Feb 18]. Available from: https://uspreventiveservicestaskforce.org/uspstf/

III. Re-Authorization

A. Transplant re-authorization must be completed annually while actively waiting for a transplant. Re-authorization documentation must be within the past 11 months (unless specified) and include the following clinical information (if testing is unable to be performed, the rationale must be included in the documentation). If the individual's health condition has not changed from the previous year some testing may not be applicable.

B. Clinical Evaluation:

1. Updated list of diagnoses to include identification of comorbidities, current assessment, and treatment plan;
2. Specialty consultation notes (if applicable);

C. Current functional ability as evidenced by current Karnofsky performance score (KPS), Palliative Performance Scale (PPS) score, ECOG, or Lansky Play-Performance Scale.

D. Follow- up Oral Health Evaluation

E. Lab Tests:

1. CBC, metabolic profile;
2. Serologies: CMV Hepatitis B and C; **and**
3. HIV testing (If applicable);

F. Cardiac Assessment:

1. 12 Lead EKG (If applicable);
2. Stress (exercise, nuclear, or dobutamine) (If applicable); and Echo or Muga scan (If applicable);

G. Pulmonary Assessment:

1. Chest x-ray (If applicable);
2. Pulmonary function tests (PFTs) for high-risk for respiratory failure (COPD, emphysema, alpha-1-antritrypsin deficiency, hepatopulmonary syndrome, or significant smoking history) (If applicable); **and**

H. Age-appropriate Screening Tests: Please refer to the USPSTF website for a list of age-appropriate screening guidelines (e.g., colorectal cancer screening, cervical cancer screening for guidance). [accessed 2026 Feb 25]. Available from: https://uspreventiveservicestaskforce.org/uspstf/

DESCRIPTION

Pancreas Transplant Alone (PTA)

A pancreas transplant is a surgical procedure that involves replacing a diseased or nonfunctioning pancreas with a healthy pancreas from a deceased or living donor. This procedure is primarily performed on individuals with IDDM who have had severe complications or are experiencing significant challenges in managing their blood sugar level. The benefits of a pancreas transplant can be not only lifesaving but can improve quality of life. A pancreas transplant can eliminate the need for insulin therapy, reduce the risk of diabetes related complications (neuropathy, retinopathy, and cardiovascular issues), and can help better manage blood sugar levels.

Pancreas after Kidney Transplant (PAK)

Pancreas transplant after a kidney transplant is a surgical procedure where a healthy pancreas is transplanted into an individual who has already received a kidney transplant. This approach is primarily aimed at individuals with IDDM who have undergone kidney transplantation and still struggle with severe diabetes management. The pancreas is usually transplanted in a separate surgical procedure after a kidney transplant has taken place.

Simultaneous Pancreas and Kidney Transplant (SPK)

A SPK is a surgical procedure that involves the transplantation of both a kidney and a pancreas during the same surgical session. This approach is primarily intended for individuals with IDDM and chronic kidney disease, or end stage renal failure. The goal is to restore kidney function, insulin production, reduce or eliminate the need for insulin therapy, improve blood glucose control and overall metabolic health. The surgeon connects the donor pancreas and kidneys to the recipient's blood vessels and urinary system. Often times, both transplanted organs may come from one deceased donor. It is also possible for the kidneys to come from a living donor (a family member or friend) and the pancreas from a deceased donor.

SPK is intended for individuals who have already developed end-stage diabetic nephropathy. The renal transplant is meant to be lifesaving, while the transplanted pancreas is indicated to slow, arrest, or reverse retinopathy or neuropathy. Additionally, the new pancreas may help the transplanted kidney function longer than if it had been transplanted without an accompanying pancreas.

Islet Cell Transplantation

Allogeneic pancreatic islet cell transplantation is a medical procedure in which islet cells (also called islets of Langerhans) are extracted from a deceased donor's pancreas using a specialized process. The extracted cells are then injected into the recipient's liver through the portal vein. The goal is for the transplanted islet cells to function in the liver and produce insulin. This procedure is primarily aimed at individuals with type 1 diabetes who have severe blood sugar control issues and cannot manage their condition with conventional therapies. The success of islet cell transplantation varies, with many recipients requiring insulin again within a few years after the transplantation.

There are inherent risks with all transplant surgeries, which include rejection of the new organ, infection, and complications from surgery. The individuals must take lifelong immunosuppressive medications to prevent organ rejection which can have side effects and increase the risk of infection. Transplant surgeries require careful medical management and continuous follow up to ensure the success of the transplant and overall health of the individual.

SUPPORTIVE LITERATURE

Pancreas Transplant

Parajuli et al (2019) described a single center's experience with 635 pancreas and kidney transplant individuals (611 SPK, 24 PAK). Transplants were performed between 2000 and 2016. The mean length of time between kidney transplant and pancreas transplant was 23.8 months in the PAK

group. Pancreas rejection rates at 1-year post-transplant were 4% and 9% with PAK and SPK, respectively. During the entire study period, PAK individuals were more likely to experience pancreas rejection (38% vs. 16%; p=.005). Kidney and pancreas graft survival rates did not differ between groups at 1 year or at last follow-up. Pancreas graft survival rates for PAK and SPK at 1 year were 100% and 89%, respectively. Death censored pancreas graft failure rates for PAK and SPK at last follow-up were 13% and 25%, respectively. Individual survival at last follow-up was similar between groups (71% with PAK vs. 68% with SPK; p=.79).

The FDA (2023) approved donislecel-jujn for the treatment of adults with type 1 diabetes who are unable to approach target HbA1C because of repeated episodes of severe hypoglycemia despite intensive diabetes management and education. The FDA approval was based on a phase 1/2 trial in individuals with brittle type 1 diabetes complicated by hypoglycemic unawareness, metabolic lability with documented severe hypoglycemia, or ketoacidosis despite intensive insulin therapy (N=10); a single-arm, open-label phase 3 trial with similar eligibility criteria (N=20); and an expanded access protocol with similar eligibility criteria.

In the FDA analysis of these trials (as described in the product labeling), median participant age was 46.5 years (range, 21 to 67 years); 80% of participants were female, 100% were White, and 97% were of non-Hispanic ethnicity. Individuals received up to 3 islet cell infusions; among 30 participants in the approval trials, 11 received 1 islet cell infusion, 12 received 2 infusions, and 7 received 3 infusions. Twenty-five participants (83%) achieved exogenous insulin independence (defined as not requiring exogenous insulin to achieve adequate glycemic control) of any duration, including 4 individuals (13.3%) with independence for less than 1 year, 12 individuals (36.7%) with independence for 1 to 5 years, and 9 individuals (33.3%) with independence for more than 5 years. Mean duration of exogenous insulin dependence in the phase 1/2 and phase 3 studies were 5.1 years and 3.2 years, respectively.

Serious adverse reactions were reported in 90%, including 2 deaths (7%) from multiorgan failure with sepsis (1.6 years after first infusion) and progressive confusion, global atrophy, and micro-ischemic disease (9.7 years after first infusion); most serious adverse reactions were attributed to immunosuppression. Infections were reported in 26 individuals (87%), totaling 211 episodes, one of which was classified as life-threatening and 22 as severe. Malignancy was reported in 11 subjects (37%), including 12 skin cancers and one each of post-transplant lymphoproliferative disease, breast cancer, and thyroid cancer. Common adverse events included, but were not limited to nausea, fatigue, anemia, diarrhea, abdominal pain, asthenia, headache, and hyponatremia. Most adverse reactions were low-grade by Common Terminology Criteria for Adverse Events, version 5; the most common grade ≥3 adverse events included low density lipoprotein elevations (37%), anemia (27%), and pneumonia (17%).

The FDA Biologics License Application Clinical Review Memorandum states numerous protocol deviations across the above studies that could impair the interpretation of both efficacy and safety data, as well as providing examples of missing and incongruent data and insufficient data monitoring during the study. The fact that the studies were conducted at a single site raises concern and other factors that might have affected occurrence or duration of insulin independence were not able to be

elucidated from the existing studies, including cell product factors (number of cells, viability, purity, and potency) and delivery device (e.g., type of catheter). Available from: https://www.fda.gov/vaccines-blood-biologics/lantidra [accessed 2026 Mar 19].

PROFESSIONAL GUIDELINE(S)

Current Organ Procurement and Transplantation Network (OPTN) policy permits HIV positive transplant candidates. The American Society of Transplantation (2019) published a guideline on solid organ transplantation in HIV-infected individuals for kidney-pancreas transplants, the following criteria for transplantation are suggested:

- Cluster of differentiation 4 count >200 cells/mL for at least 3 months (insufficient data to recommend for or against transplantation in individuals with counts >100 cells/mL and no history of opportunistic infection);
- undetectable HIV viral load while receiving antiretroviral therapy; documented compliance with a stable antiretroviral therapy regimen;
- absence of active opportunistic infection and malignancy;
- absence of chronic wasting or severe malnutrition; and appropriate follow-up with providers experienced in HIV management and ready access to immunosuppressive medication therapeutic drug monitoring (Blumberg et al 2019).

Effective March 15, 2021, the Organ Procurement and Transplantation Network (OPTN) has launched a new policy for matching kidney and pancreas transplant candidates with organs from deceased donors. The new policy is projected to increase equity in transplant access for candidates nationwide. It replaces distribution based on donation service area (DSA) and OPTN region with a more consistent measure of distance between the donor hospital and the transplant hospital for each candidate.

According to the 2021 American Diabetes Association (ADA) and the European Association for the Study of Diabetes (EASD) consensus report, β-cell replacement may serve as a therapeutic option for individuals who experience severe metabolic complications including severe hypoglycemia and hypoglycemia unawareness. Whole pancreas transplant and pancreatic islet transplantation both require lifelong immunosuppression. The ADA/EASD suggests carefully considering the risks versus benefit of β-cell replacement because of the need for chronic immunosuppression. The consensus report does note that these approaches have not been compared to newer closed-loop technology, which could avoid immunosuppression altogether.

The ADA addresses pancreas and islet transplantation in the Pharmacologic Approaches to Glycemic Treatment section of the 2026 Standards of Care in Diabetes stating that "successful pancreas and islet transplantation can normalize glucose levels and mitigate microvascular complications of type 1 diabetes, however, people receiving these treatments require lifelong immunosuppression to prevent graft rejection and/or recurrence of autoimmune islet destruction, and given the potential adverse effects of immunosuppressive therapy, pancreas transplant should be reserved for people with type 1 diabetes undergoing simultaneous kidney transplant, following kidney transplantation or for those

with recurrent ketoacidosis or severe hypoglycemia despite optimized glycemic management."

REGULATORY STATUS

Organ transplants, as surgical procedures, do not require U.S. Food and Drug Administration (FDA) approval. The Health Resources Services Administration (HRSA) oversees the transplantation of vascularized human organs through the Organ Procurement and Transplantation Network (OPTN). For more information view the OPTN: https://www.hrsa.gov/optn [accessed 2026 February 27].

On June 28, 2023, the FDA approved Lantidra (donislecel-jujn), an allogeneic (donor) pancreatic islet cellular therapy. Lantidra was approved for the treatment of adults with type 1 diabetes who are unable to approach target glycosylated hemoglobin (average blood glucose levels) because of repeated episodes of severe hypoglycemia (low blood sugar) despite intensive diabetes management and education. The primary mechanism of action of Lantidra is the secretion of insulin by the infused allogeneic islet beta cells. In some individuals with type 1 diabetes, these infused cells can produce enough insulin, so the individual no longer needs to take insulin to control their blood sugar levels. Lantidra is administered as a single infusion into the hepatic (liver) portal vein. An additional infusion of Lantidra may be performed depending on the individual's response to the initial dose. A total of three infusions may be performed based on the individual's response. Lifelong immunosuppression is required to maintain islet cell viability.

CODE(S)

- Codes may not be covered under all circumstances.
- Code list may not be all inclusive (AMA and CMS code updates may occur more frequently than policy updates).
- (E/I)=Experimental/Investigational
- (NMN)=Not medically necessary/appropriate

CPT Codes

Code	Description
48160	Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islet cells
48552	Backbench reconstruction of cadaver donor pancreas allograft prior to transplantation, venous anastomosis, each
48554	Transplantation of pancreatic allograft
48556	Removal of transplanted pancreatic allograft
50340	Recipient nephrectomy (separate procedure)
50360	Renal allotransplantation, implantation of graft; without recipient nephrectomy

Code	Description
50365	with recipient nephrectomy
50370	Removal of transplanted renal allograft
0584T*	Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including guidance, and radiological supervision and interpretation, when performed; percutaneous (*E/I for Lantidra use)
0585T*	Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including guidance, and radiological supervision and interpretation, when performed; laparoscopic (*E/I for Lantidra use)
0586T*	Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including guidance, and radiological supervision and interpretation, when performed; open (*E/I for Lantidra use)

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HCPCS Codes

Code	Description
G0341*	Percutaneous islet cell transplant, includes portal vein catheterization and infusion (*E/I for Lantidra use)
G0342*	Laparoscopy for islet cell transplant, includes portal vein catheterization and infusion (*E/I for Lantidra use)
G0343*	Laparotomy for islet cell transplant, includes portal vein catheterization and infusion (*E/I for Lantidra use)
S2102*	Islet cell tissue transplant from pancreas; allogeneic (*E/I for Lantidra use)
S2065	Simultaneous pancreas kidney transplantation

ICD10 Codes

Code	Description
E09.21-E09.29	Drug or chemical induced diabetes mellitus with diabetic nephropathy and kidney complications (code range)
E10.10-E10.9	Type 1 diabetes mellitus (code range)
E11.00-E11.9	Type 2 diabetes mellitus (code range)
E13.00-E13.29	Other specified diabetes mellitus with hyperosmolarity, or ketoacidosis, or kidney complications (code range)
E13.40-E13.59	Other specified diabetes mellitus with neurological or circulatory complications (code range)
E13.610-E13.9	Other specified diabetes mellitus with or without other specified complications, or without complications (code range)
M32.14	Glomerular disease in systemic lupus erythematosus
M32.15	Tubulo-interstitial nephropathy in systemic lupus erythematosus
M35.04	Sjogren syndrome with tubulo-interstitial nephropathy
N08	Glomerular disorders in diseases classified elsewhere
N16	Renal tubulo-interstitial disorders in diseases classified elsewhere
N18.1-N18.9	Chronic kidney disease (CKD) (code range)
T86.890-T89.899	Complications of other transplanted tissue (code range)

REFERENCES

American Diabetes Association Professional Practice Committee for Diabetes. 9. Pharmacologic approaches to glycemic treatment: standards of care in diabetes-2026. Diabetes Care. 2026;49(Suppl. 1):S183-S215.

Benjamens S, et al. A steady decline in pancreas transplantation rates. Pancreatology. 2019 Jan;19(1):31-38.

Blumberg EA, et al. American Society of Transplantation Infectious Diseases Community of Practice. Solid organ transplantation in the HIV-infected patient: Guidelines from the American Society of Transplantation Infectious Diseases Community of Practice. Clin Transplant. 2019 Sep;33(9):e13499.

Esmeijer K, et al. Dutch Transplant Centers; Dutch Kidney Transplant Centres. Superior long-term survival for simultaneous pancreas-kidney transplantation as renal replacement therapy: 30-year follow-up of a nationwide cohort. Diabetes Care. 2020 Feb;43(2):321-328.

Holt RIG, et al. The Management of Type 1 Diabetes in adults. a consensus report by the American Diabetes Association (ADA) and the European Association for the study of diabetes (EASD). Diabetes Care. 2021 Nov;44(11):2589-2625.

Jarmi T, et al. Comparing outcomes and cost between pancreas transplant and standard of care in patients with type 1 diabetes. Pancreas. 2022 May 1;51(5):483-489.

Jones JM, et al. Assessing solid organ donors and monitoring transplant recipients for human immunodeficiency virus, hepatitis B virus, and hepatitis C virus infection - U.S. Public Health Service Guideline, 2020. MMWR Recomm Rep. 2020 Jun 26;69(4):1-16.

Lombardo C, et al. Update on pancreatic transplantation in the management of diabetes. 2021 Aug 17. Endotext [Internet]. South Dartmouth (MA): MDText.com, Inc.; 2000.

Organ Procurement and Transplantation Network (OPTN). [Internet]. OPTN Policies. 2024 Dec 11; [accessed 2026 Jan 30] Available from: https://optn.transplant.hrsa.gov/media/1200/optn_policies.pdf

Parajuli S, et al. Outcomes after simultaneous kidney-pancreas versus pancreas after kidney transplantation in the current era. Clin Transplant. Dec 2019; 33(12).

Rickels MR, Robertson RP. Pancreatic islet transplantation in humans: Recent progress and future directions. Endocr Rev. 2019 Apr 1;40(2):631-668.

SEARCH TERMS

Not Applicable

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

NCD - Pancreas Transplants (260.3) [accessed 2026 Feb 25]

NCD - Islet Cell Transplantation in the Context of a Clinical Trial (260.3.1) (cms.gov) [accessed 2026 Feb 25]

PRODUCT DISCLAIMER

- Services are contract dependent; if a product does not cover a service, medical policy criteria do not apply.
- If a commercial product (including an Essential Plan or Child Health Plus product) covers a specific service, medical policy criteria apply to the benefit.
- If a Medicaid product covers a specific service, and there are no New York State Medicaid guidelines (eMedNY) criteria, medical policy criteria apply to the benefit.
- If a Medicare product (including Medicare HMO-Dual Special Needs Program (DSNP) product) covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.
- If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.

POLICY HISTORY/REVISION

Committee Approval Dates	
10/18/01, 06/20/02, 04/24/03, 02/19/04, 02/17/05, 02/16/06, 02/15/07, 01/17/08, 03/19/09, 03/18/10, 05/19/11, 05/24/12, 05/23/13, 07/17/14, 06/18/15, 05/26/16, 01/19/17, 01/18/18, 01/17/19, 01/16/20, 01/21/21, 01/20/22, 01/19/23, 03/21/24, 03/20/25, 03/19/26	
Date	**Summary of Changes**
03/19/26	• Annual review, no change to policy intent.
03/20/25	• Annual Review, policy intent unchanged, revision of supportive literature.
01/01/25	• Summary of changes tracking implemented.
10/18/01	• Original effective date