Recommended Clincal Review (Predetermination), Medical Necessity and Non-Covered Services
2023 Commercial Benefit Procedure Code List - Fully Insured
Posted April 2023

EXCEPT AS OTHERWISE NOTED IN THE DATE COLUMN, THESE CODES ARE EFFECTIVE ON OR BEFORE JANUARY 1, 2023.

Our medical policy impacts all our coverage decisions. This list includes Current Procedural Terminology (CPT®) and/or Healthcare Common Procedure Coding System (HCPCS) codes that, based on our medical policy, are:
- Subject to a medical necessity review,
- Candidates for a Recommended Clinical Review (Predetermination),
- Not a benefit for our members,
- Considered experimental, investigational and unproven (EIU), or
- Not on our prior authorization list (with some exceptions based on members' benefit plans)

This is not an exhaustive list of all codes. Codes may change, and this list may be updated throughout the year. The presence of codes on this list does not necessarily indicate coverage under the member benefits contract. Member contracts differ in their benefits. Please use Availity® or your preferred vendor to verify eligibility & benefits and to determine if a prior authorization is required.

BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. All BCBSOK Medical Policies can be found at BCBSOK website. See link below.

The purpose of a Recommended Clinical Review (Predetermination) request is to determine whether a specific service, including services that may be considered Experimental/Investigational/Unproven, is Medically Necessary. A Recommended Clinical Review (Predetermination) is not a guarantee of Benefits or a substitute for the Preauthorization process. Refer to the Utilization Management section on our website.

Procedure Code Groups	
Medical Policy Criteria	Procedures and services are reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.
	Highlighted procedures/services in this code group may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website.
Non Covered	Procedures/services not covered by BCBSOK. Not subject to utilization review.
Experimental, Investigational, Unproven (EIU)	Procedures/services not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).
Unlisted or Undefined	Procedures/services not otherwise defined or classified, and may be subject to benefit and/or clinical review.

PRESS "CTRL" AND "F" KEYS AT THE SAME TIME TO BRING UP THE SEARCH BOX. ENTER A PROCEDURE CODE OR DESCRIPTION OF THE SERVICE.

Note: Some codes will appear twice if Ending Date and Effective Date are within the same quarter period.

Code	Code Description	Code Group & Description	Effective Date	Ending Date	Updates
00640	ANESTH SPINE MANIPULATION	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
00797	ANESTH SURGERY FOR OBESITY	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
11055	Trim Skin Lesion	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
11056	Trim Skin Lesions 2 To 4	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
11057	Trim Skin Lesions Over 4	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
11200	REMOVAL OF SKIN TAGS <W/15	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
11201	REMOVE SKIN TAGS ADD-ON	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
11719	Trim Nail(S) Any Number	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
11920	Correct Skin Color 6.0 Cm/<	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
11921	Correct Skn Color 6.1-20.0Cm	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
11922	Correct Skin Color Ea 20.0Cm	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
11950	TX CONTOUR DEFECTS 1 CC/<	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
11951	TX CONTOUR DEFECTS 1.1-5.0CC	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
11952	TX CONTOUR DEFECTS 5.1-10CC	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
11954	TX CONTOUR DEFECTS >10.0 CC	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
11960	INSERT TISSUE EXPANDER(S)	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–

11970	RPLCMT TISS XPNDR PERM IMPLT	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
11980	IMPLANT HORMONE PELLET(S)	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
11981	INSERTION DRUG DLVR IMPLANT	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
11982	Remove Drug Implant Device	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
11983	REMOVE/INSERT DRUG IMPLANT	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
15271	Skin Sub Graft Trnk/Arm/Leg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	4/1/2023	_	Add effective 04/01/2023
15272	Skin Sub Graft T/A/L Add-On	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	4/1/2023	_	Add effective 04/01/2023
15273	Skin Sub Grft T/Arm/Lg Child	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	4/1/2023	_	Add effective 04/01/2023
15274	Skn Sub Grft T/A/L Child Add	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	4/1/2023	_	Add effective 04/01/2023
15275	Skin Sub Graft Face/Nk/Hf/G	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	4/1/2023	_	Add effective 04/01/2023
15276	Skin Sub Graft F/N/Hf/G Addl	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	4/1/2023	_	Add effective 04/01/2023
15277	Skn Sub Grft F/N/Hf/G Child	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	4/1/2023	_	Add effective 04/01/2023
15278	Skn Sub Grft F/N/Hf/G Ch Add	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	4/1/2023	_	Add effective 04/01/2023
15758	FREE FASCIAL FLAP MICROVASC	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
15769	GRFG AUTOL SOFT TISS DIR EXC	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
15771	GRFG AUTOL FAT LIPO 50 CC/<	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
15772	GRFG AUTOL FAT LIPO EA ADDL	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
15775	HAIR TRNSPL 1-15 PUNCH GRFTS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
15776	HAIR TRNSPL >15 PUNCH GRAFTS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
15780	DERMABRASION TOTAL FACE	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
15781	DERMABRASION SEGMENTAL FACE	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
15782	DERMABRASION OTHER THAN FACE	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
15783	DERMABRASION SUPRFL ANY SITE	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
15786	ABRASION LESION SINGLE	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
15787	ABRASION LESIONS ADD-ON	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
15788	CHEMICAL PEEL FACE EPIDERM	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
15789	CHEMICAL PEEL FACE DERMAL	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
15792	CHEMICAL PEEL NONFACIAL	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
15793	CHEMICAL PEEL NONFACIAL	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
15819	PLASTIC SURGERY NECK	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
15820	REVISION OF LOWER EYELID	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
15821	REVISION OF LOWER EYELID	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
15822	REVISION OF UPPER EYELID	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
15823	REVISION OF UPPER EYELID	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
15825	REMOVAL OF NECK WRINKLES	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
15828	REMOVAL OF FACE WRINKLES	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
15829	REMOVAL OF SKIN WRINKLES	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
15830	EXC SKIN ABD	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
15832	EXCISE EXCESSIVE SKIN THIGH	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
15833	EXCISE EXCESSIVE SKIN LEG	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
15834	EXCISE EXCESSIVE SKIN HIP	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
15835	EXCISE EXCESSIVE SKIN BUTTCK	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
15836	EXCISE EXCESSIVE SKIN ARM	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
15837	EXCISE EXCESS SKIN ARM/HAND	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
15838	EXCISE EXCESS SKIN FAT PAD	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
15839	EXCISE EXCESS SKIN & TISSUE	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
15847	EXC SKIN ABD ADD-ON	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
15876	SUCTION LIPECTOMY HEAD&NECK	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
15877	SUCTION LIPECTOMY TRUNK	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
15878	SUCTION LIPECTOMY UPR EXTREM	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–

15879	SUCTION LIPECTOMY LWR EXTREM	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
15999	UNLISTED PX EXC PRESSURE ULC	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
17106	DESTRUCTION OF SKIN LESIONS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
17107	DESTRUCTION OF SKIN LESIONS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
17108	DESTRUCTION OF SKIN LESIONS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
17340	CRYOTHERAPY OF SKIN	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
17360	SKIN PEEL THERAPY	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
17380	HAIR REMOVAL BY ELECTROLYSIS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
17999	UNLISTD PX SKN MUC MEMB SUBQ	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
19105	CRYOSURG ABLATE FA EACH	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
19300	REMOVAL OF BREAST TISSUE	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
19303	MAST SIMPLE COMPLETE	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
19325	BREAST AUGMENTATION W/IMPLT	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
19328	RMVL INTACT BREAST IMPLANT	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
19330	RMVL RUPTURED BREAST IMPLANT	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
19340	INSJ BREAST IMPLT SM D MAST	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
19342	INSJ/RPLCMT BRST IMPLT SEP D	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
19350	BREAST RECONSTRUCTION	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
19355	CORRECT INVERTED NIPPLE(S)	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
19357	TISS XPNDR PLMT BRST RCNSTJ	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
19370	REVJ PERI-IMPLT CAPSULE BRST	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
19371	PERI-IMPLT CAPSLC BRST COMPL	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
19499	UNLISTED PROCEDURE BREAST	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
20527	INJ DUPUYTREN CORD W/ENZYME	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
20560	NDL INSJ W/O NJX 1 OR 2 MUSC	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
20561	NDL INSJ W/O NJX 3+ MUSC	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
20979	US BONE STIMULATION	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
20982	ABLATE BONE TUMOR(S) PERQ	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
20985	CPTR-ASST DIR MS PX	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
20999	UNLISTED PX MUSCSKEL GENERAL	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
21073	MNPJ OF TMJ W/ANESTH	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
21083	PREPARE FACE/ORAL PROSTHESIS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
21089	UNLISTED MAXLFCL PROSTH PX	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
21120	RECONSTRUCTION OF CHIN	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
21121	RECONSTRUCTION OF CHIN	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
21122	RECONSTRUCTION OF CHIN	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
21123	RECONSTRUCTION OF CHIN	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
21244	RECONSTRUCTION OF LOWER JAW	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
21245	RECONSTRUCTION OF JAW	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
21246	RECONSTRUCTION OF JAW	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
21247	Reconstruct Lower Jaw Bone	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
21248	RECONSTRUCTION OF JAW	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
21249	RECONSTRUCTION OF JAW	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
21299	UNLISTED CRANFCL&MAXLFCL PX	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
21499	UNLISTED MUSCSKEL PX HEAD	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
21685	Hyoid Myotomy & Suspension	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
21740	Reconstruction Of Sternum	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
21742	Repair Stern/Nuss W/O Scope	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
21743	Repair Sternum/Nuss W/Scope	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
21899	UNLISTED PX NECK/THORAX	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
22505	MANIPULATION OF SPINE	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
22526	IDET SINGLE LEVEL	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–

22527	IDET 1 OR MORE LEVELS	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
22586	ARTHRD PRE-SAC NTRBDY L5-S1	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
22867	INSJ STABLJ DEV W/DCMPRN	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
22868	INSJ STABLJ DEV W/DCMPRN	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
22869	INSJ STABLJ DEV W/O DCMPRN	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
22870	INSJ STABLJ DEV W/O DCMPRN	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
22899	UNLISTED PROCEDURE SPINE	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
22999	UNLISTED PX ABDOMEN MUSCSKEL	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
23929	UNLISTED PROCEDURE SHOULDER	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
24300	MNPJ ELBOW UNDER ANES	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
24999	UNLISTED PX HUMERUS/ELBOW	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
25259	MANIPULATE WRIST W/ANESTHES	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
25999	UNLISTED PX FOREARM/WRIST	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
26340	MANIPULATE FINGER W/ANESTH	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
26341	MANIPULAT PALM CORD POST INJ	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
26989	UNLISTED PX HANDS/FINGERS	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
27257	Treat Hip Dislocation	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
27275	MANIPULATION OF HIP JOINT	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
27280	ARTHR SI JT OPN B1GRF INSTRM	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
27299	UNLISTED PX PELVIS/HIP JOINT	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
27599	UNLISTED PX FEMUR/KNEE	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
27702	RECONSTRUCT ANKLE JOINT	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
27703	RECONSTRUCTION ANKLE JOINT	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
27704	Removal Of Ankle Implant	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
27860	FIXATION OF ANKLE JOINT	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
27899	UNLISTED PX LEG/ANKLE	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
28890	HI ENRGY ESWT PLANTAR FASCIA	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
28899	UNLISTED PX FOOT/TOES	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
29799	UNLISTED PX CASTING/STRPG	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
29862	HIP ARTHR0 W/DEBRIDEMENT	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
29866	AUTGRFT IMPLNT KNEE W/SCOPE	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
29867	ALLGRFT IMPLNT KNEE W/SCOPE	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
29868	MENISCAL TRNSPL KNEE W/SCPE	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
29914	HIP ARTHRO W/FEMOROPLASTY	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
29915	HIP ARTHRO ACETABULOPLASTY	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
29916	HIP ARTHRO W/LABRAL REPAIR	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
29999	UNLISTED PX ARTHROSCOPY	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
30468	RPR NSL VLV COLLAPSE W/IMPLT	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
30469	RPR NSL VLV COLLAPSE W/RMDLG	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	1/1/2023	–	Add effective 01/01/2023
30999	UNLISTED PROCEDURE NOSE	Unlisted Procedure; May require Prior Authorization per contract agreement.	–	–	–
31295	Nsl/Sins Ndsc Surg Max Sins	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
31298	Nsl/Sins Ndsc Surg Frnt&Sphn	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
31299	UNLISTED PX ACCESSORY SINUS	Unlisted Procedure; May require Prior Authorization per contract agreement.	–	–	–
31572	Largsc W/Laser Dstrj Les	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
31573	Largsc W/Ther Injection	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
31574	Largsc W/Njx Augmentation	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
31599	UNLISTED PROCEDURE LARYNX	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
31627	Navigational Bronchoscopy	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
31634	Bronch W/Balloon Occlusion	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
31647	BRONCHIAL VALVE INIT INSERT	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
31648	BRONCHIAL VALVE REMOV INIT	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
31649	BRONCHIAL VALVE REMOV ADDL	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
31651	BRONCHIAL VALVE ADDL INSERT	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
31660	BRONCH THERMOPLSTY 1 LOBE	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–

31661	BRONCH THERMOPLSTY 2/> LOBES	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
31899	UNLISTED PX TRACHEA BRONCHI	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
32553	Ins Mark Thor For Rt Perq	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
32664	Thoracoscopy W/ Th Nrv Exc	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
32994	ABLATE PULM TUMOR PERQ CRYBL	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
32998	ABLATE PULM TUMOR PERQ RF	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
32999	UNLISTED PX LUNGS & PLEURA	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
33211	INSERT CARD ELECTRODES DUAL	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33213	INSERT PULSE GEN DUAL LEADS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33225	L VENTRIC PACING LEAD ADD-ON	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33267	EXCL LAA OPEN ANY METHOD	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33268	EXCL LAA OPN OTH PX ANY METH	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33269	EXCL LAA THRSCP ANY METHOD	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33270	Ins/Rep Subq Defibrillator	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33271	Insj Subq Impltbl Dfb Elctrd	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33274	TCAT INSJ/RPL PERM LDLS PM	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33275	Tcat Rmvl Perm Ldls Pm W/Img	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33285	INSJ SUBQ CAR RHYTHM MNTR	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33289	TCAT IMPL WRLS P-ART PRS SNR	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33340	Perq Clsr Tcat L Atr Apndge	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33361	REPLACE AORTIC VALVE PERQ	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33362	REPLACE AORTIC VALVE OPEN	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33363	REPLACE AORTIC VALVE OPEN	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33364	REPLACE AORTIC VALVE OPEN	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33365	REPLACE AORTIC VALVE OPEN	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33366	TRCATH REPLACE AORTIC VALVE	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33367	REPLACE AORTIC VALVE W/BYP	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33368	REPLACE AORTIC VALVE W/BYP	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33369	REPLACE AORTIC VALVE W/BYP	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33418	REPAIR TCAT MITRAL VALVE	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33419	REPAIR TCAT MITRAL VALVE	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33477	IMPLANT TCAT PULM VLV PERQ	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33542	Removal Of Heart Lesion	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33880	Endovasc Taa Repr Incl Subcl	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33881	Endovasc Taa Repr W/O Subcl	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33883	Insert Endovasc Prosth Taa	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33884	Endovasc Prosth Taa Add-On	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33886	Endovasc Prosth Delayed	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33889	Artery Transpose/Endovas Taa	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33927	IMPLTJ TOT RPLCMT HRT SYS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33928	RMVL & RPLCMT TOT HRT SYS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33929	Rmvl Rplcmt Hrt Sys F/Trnspl	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33975	Implant Ventricular Device	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33976	Implant Ventricular Device	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33979	Insert Intracorporeal Device	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33981	Replace Vad Pump Ext	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33982	Replace Vad Intra W/O Bp	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33983	Replace Vad Intra W/Bp	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33990	Insj Perq Vad L Hrt Arterial	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33991	Insj Perq Vad L Hrt Artl&Ven	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33992	Rmvl Perq Left Heart Vad	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–

33993	Reposg Perq R/L Hrt Vad	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
33999	UNLISTED PX CARDIAC SURGERY	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
36260	Insertion Of Infusion Pump	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
36299	UNLISTED PX VASCULAR NJX	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
36465	NJX NONCMPND SCLRSNT 1 VEIN	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
36466	NJX NONCMPND SCLRSNT MLT VN	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
36468	NJX SCLRSNT SPIDER VEINS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
36470	NJX SCLRSNT 1 INCMPTNT VEIN	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
36471	NJX SCLRSNT MLT INCMPTNT VN	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
36473	ENDOVENOUS MCHNCHEM 1ST VEIN	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
36474	ENDOVENOUS MCHNCHEM ADD-ON	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
36475	ENDOVENOUS RF 1ST VEIN	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
36476	ENDOVENOUS RF VEIN ADD-ON	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
36478	ENDOVENOUS LASER 1ST VEIN	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
36479	ENDOVENOUS LASER VEIN ADDON	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
36482	ENDOVEN THER CHEM ADHES 1ST	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
36483	ENDOVEN THER CHEM ADHES SBSQ	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
36511	Apheresis Wbc	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
36522	PHOTOPHERESIS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
36563	Insert Tunneled Cv Cath	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
36836	PRQ AV FSTL CRTJ UXTR 1 ACS	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	1/1/2023	–	Add effective 01/01/2023
36837	PRQ AV FSTL CRT UXTR SEP ACS	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	1/1/2023	–	Add effective 01/01/2023
37215	TRANSCATH STENT CCA W/EPS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
37216	TRANSCATH STENT CCA W/O EPS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
37217	STENT PLACEMT RETRO CAROTID	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
37218	STENT PLACEMT ANTE CAROTID	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
37241	VASC EMBOLIZE/OCCLUDE VENOUS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
37242	VASC EMBOLIZE/OCCLUDE ARTERY	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
37243	VASC EMBOLIZE/OCCLUDE ORGAN	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
37244	VASC EMBOLIZE/OCCLUDE BLEED	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
37500	ENDOSCOPY LIGATE PERF VEINS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
37501	UNLISTED VASC ENDOSCOPY PX	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
37700	REVISE LEG VEIN	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
37718	LIGATE/STRIP SHORT LEG VEIN	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
37722	LIGATE/STRIP LONG LEG VEIN	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
37735	REMOVAL OF LEG VEINS/LESION	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
37760	LIGATE LEG VEINS RADICAL	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
37761	LIGATE LEG VEINS OPEN	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
37765	STAB PHLEB VEINS XTR 10-20	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
37766	PHLEB VEINS - EXTREM 20+	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
37780	REVISION OF LEG VEIN	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
37785	LIGATE/DIVIDE/EXCISE VEIN	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
37788	Revascularization Penis	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
37790	PENILE VENOUS OCCLUSION	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
37799	UNLISTED PX VASCULAR SURGERY	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
38129	UNLISTED LAPS PX SPLEEN	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
38204	BL DONOR SEARCH MANAGEMENT	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
38205	HARVEST ALLOGENEIC STEM CELL	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
38206	HARVEST AUTO STEM CELLS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	–	–	–
38207	CRYOPRESERVE STEM CELLS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
38208	THAW PRESERVED STEM CELLS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–

38209	WASH HARVEST STEM CELLS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
38210	T-CELL DEPLETION OF HARVEST	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
38211	TUMOR CELL DEPLETE OF HARVST	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
38212	RBC DEPLETION OF HARVEST	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
38213	PLATELET DEPLETE OF HARVEST	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
38214	VOLUME DEPLETE OF HARVEST	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
38215	HARVEST STEM CELL CONCENTRTE	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
38230	BONE MARROW HARVEST ALLOGEN	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
38232	BONE MARROW HARVEST AUTOLOG	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
38240	TRANSPLT ALLO HCT/DONOR	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
38241	TRANSPLT AUTOL HCT/DONOR	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
38242	TRANSPLT ALLO LYMPHOCYTES	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
38243	TRANSPLJ HEMATOPOIETIC BOOST	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
38308	INCISION OF LYMPH CHANNELS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
38589	UNLISTED LAPS PX LYMPHTC SYS	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
38999	UNLISTD PX HEMIC/LYMPHTC SYS	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
39499	UNLISTED PX MEDIASTINUM	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
39599	UNLISTED PX DIAPHRAGM	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
40799	UNLISTED PROCEDURE LIPS	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
40899	UNLISTED PX VESTIBULE MOUTH	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
41120	Partial Removal Of Tongue	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
41512	TONGUE SUSPENSION	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
41530	TONGUE BASE VOL REDUCTION	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
41599	UNLISTED PX TONGUE FLR MOUTH	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
41899	UNLISTED PX DENTALVLR STRUX	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
42140	EXCISION OF UVULA	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
42145	REPAIR PALATE PHARYNX/UVULA	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
42299	UNLISTED PX PALATE UVULA	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
42699	UNLISTED PX SALIVRY GLND/DUX	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
42999	UNLISTED PX PHRNX ADND/TNSL	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
43192	Esophagoscp Rig Trnso Inject	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43201	Esoph Scope W/Submucous Inj	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43206	ESOPH OPTICAL ENDOMICROSCOPY	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
43210	EGD ESOPHAGOGASTRC FNDOPLSTY	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43236	UPPR GI SCOPE W/SUBMUC INJ	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43252	EGD OPTICAL ENDOMICROSCOPY	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
43253	EGD US TRANSMURAL INJXN/MARK	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43257	EGD W/THRML TXMNT GERD	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43284	LAPS ESOPHGL SPHNCTR AGMNTJ	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43285	Rmvl Esophgl Sphnctr Dev	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43289	UNLISTED LAPS PX ESOPH	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43290	EGD FLX TRNSORL DPLMNT BALO	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	1/1/2023	_	Add effective 01/01/2023
43291	EGD FLX TRNSORL RMVL BALO	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	1/1/2023	_	Add effective 01/01/2023
43312	Repair Esophagus And Fistula	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43499	UNLISTED PROCEDURE ESOPHAGUS	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
43633	REMOVAL OF STOMACH PARTIAL	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43644	LAP GASTRIC BYPASS/ROUX-EN-Y	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43645	LAP GASTR BYPASS INCL SMLL I	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43659	UNLISTED LAPS PX STOMACH	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
43770	LAP PLACE GASTR ADJ DEVICE	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43771	LAP REVISE GASTR ADJ DEVICE	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43772	LAP RMVL GASTR ADJ DEVICE	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43773	LAP REPLACE GASTR ADJ DEVICE	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

43774	LAP RMVL GASTR ADJ ALL PARTS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
43775	LAP SLEEVE GASTRECTOMY	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
43842	V-BAND GASTROPLASTY	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
43843	GASTROPLASTY W/O V-BAND	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
43845	GASTROPLASTY DUODENAL SWITCH	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
43846	GASTRIC BYPASS FOR OBESITY	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
43847	GASTRIC BYPASS INCL SMALL I	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
43848	REVISION GASTROPLASTY	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
43860	Revise Stomach-Bowel Fusion	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
43886	REVISE GASTRIC PORT OPEN	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
43887	REMOVE GASTRIC PORT OPEN	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
43888	CHANGE GASTRIC PORT OPEN	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
43999	UNLISTED PROCEDURE STOMACH	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
44238	UNLISTED LAPS PX INTESTINE	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
44640	Repair Bowel-Skin Fistula	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
44705	PREPARE FECAL MICROBIOTA	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
44799	UNLISTED PX SMALL INTESTINE	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
44899	UNLISTED PX MECKEL'S DVRTCLM	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
44979	UNLISTED LAPS PX APPENDIX	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
45399	UNLISTED PROCEDURE COLON	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
45499	LAPAROSCOPE PROC RECTUM	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
45999	UNLISTED PROCEDURE RECTUM	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
46707	REPAIR ANORECTAL FIST W/PLUG	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
46999	UNLISTED PROCEDURE ANUS	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
47370	LAPARO ABLATE LIVER TUMOR RF	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
47379	UNLISTED LAPS PX LIVER	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
47380	OPEN ABLATE LIVER TUMOR RF	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
47381	Open Ablate Liver Tumor Cryo	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
47382	PERCUT ABLATE LIVER RF	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
47399	UNLISTED PROCEDURE LIVER	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
47579	UNLISTED LAPS PX BILIARY TRC	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
47999	UNLISTED PX BILIARY TRACT	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
48999	UNLISTED PROCEDURE PANCREAS	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
49329	UNLSTD LAPS PX ABD PERTM&OMN	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
49411	Ins Mark Abd/Pel For Rt Perq	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
49412	Ins Device For Rt Guide Open	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
49659	UNLSTD LAPS PX HRNAP HRNRPHY	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
49999	UNLISTED PX ABD PERTM&OMN	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
50250	CRYOABLATE RENAL MASS OPEN	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
50360	TRANSPLANTATION OF KIDNEY	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
50541	LAPARO ABLATE RENAL CYST	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
50542	LAPARO ABLATE RENAL MASS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
50549	UNLISTED LAPS PX RENAL	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
50592	PERC RF ABLATE RENAL TUMOR	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
50593	PERC CRYO ABLATE RENAL TUM	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
50949	UNLISTED LAPS PX URETER	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
51715	ENDOSCOPIC INJECTION/IMPLANT	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
51999	UNLISTED LAPS PX BLADDER	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
52287	Cystoscopy Chemodenervation	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
52327	CYSTOSCOPY INJECT MATERIAL	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
52441	CYSTOURETHRO W/IMPLANT	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
52442	CYSTOURETHRO W/ADDL IMPLANT	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
53855	INSERT PROST URETHRAL STENT	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
53860	TRANSURETHRAL RF TREATMENT	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
53899	UNLISTED PX URINARY SYSTEM	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
54110	Treatment Of Penis Lesion	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–

54111	Treat Penis Lesion Graft	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
54112	Treat Penis Lesion Graft	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
54125	REMOVAL OF PENIS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
54200	TREATMENT OF PENIS LESION	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
54205	TREATMENT OF PENIS LESION	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
54235	Penile Injection	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
54240	PENIS STUDY	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
54360	Penis Plastic Surgery	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
54400	INSERT SEMI-RIGID PROSTHESIS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
54401	INSERT SELF-CONTD PROSTHESIS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
54405	INSERT MULTI-COMP PENIS PROS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
54406	REMOVE MUTI-COMP PENIS PROS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
54408	REPAIR MULTI-COMP PENIS PROS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
54410	REMOVE/REPLACE PENIS PROSTH	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
54411	REMOV/REPLC PENIS PROS COMP	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
54415	REMOVE SELF-CONTD PENIS PROS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
54416	REMV/REPL PENIS CONTAIN PROS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
54417	REMV/REPLC PENIS PROS COMPL	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
54440	Repair Of Penis	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
54660	REVISION OF TESTIS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
54699	UNLISTED LAPS PX TESTIS	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
55400	Repair Of Sperm Duct	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
55559	UNLSTD LAPS PX SPRMATIC CORD	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
55706	PROSTATE SATURATION SAMPLING	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
55870	Electroejaculation	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
55873	CRYOABLATE PROSTATE	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
55876	Place Rt Device/Marker Pros	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
55880	ABLTJ MAL PRST8 TISS HIFU	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
55899	UNLISTED PX MALE GENITAL SYS	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
55970	SEX TRANSFORMATION M TO F	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
55980	SEX TRANSFORMATION F TO M	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
56805	REPAIR CLITORIS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
56810	REPAIR OF PERINEUM	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
57291	CONSTRUCTION OF VAGINA	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
57292	CONSTRUCT VAGINA WITH GRAFT	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
57295	Revise Vag Graft Via Vagina	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
57296	REVISE VAG GRAFT OPEN ABD	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
57307	Fistula Repair & Colostomy	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
57335	REPAIR VAGINA	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
57426	REVISE PROSTH VAG GRAFT LAP	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
58321	ARTIFICIAL INSEMINATION	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
58322	ARTIFICIAL INSEMINATION	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
58323	SPERM WASHING	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
58578	UNLISTED LAPS PX UTERUS	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
58579	UNLISTED HYSTSC PX UTERUS	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
58674	Laps Abltj Uterine Fibroids	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
58679	UNLISTED LAPS PX OVIDCT OVRY	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
58750	REPAIR OVIDUCT	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
58752	Revise Ovarian Tube(S)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
58970	Retrieval Of Oocyte	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
58974	Transfer Of Embryo	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
58976	Transfer Of Embryo	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
58999	UNLISTED PX FML GENITAL SYS	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
59074	FETAL FLUID DRAINAGE W/US	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
59076	Fetal Shunt Placement W/Us	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

59897	UNLISTED FETAL INVAS PX W/US	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
59898	UNLSTD LAPS PX MAT CARE&DLVR	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
59899	UNLISTED PX MAT CARE&DLVR	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
60659	UNLISTED LAPS PX ENDOC SYS	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
60699	UNLISTED PX ENDOCRINE SYSTEM	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
61215	Insert Brain-Fluid Device	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
61630	INTRACRANIAL ANGIOPLASTY	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
61645	PERQ ART M-THROMBECT &/NFS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
61650	Evasc Prlng Admn Rx Agnt 1St	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
61651	Evasc Prlng Admn Rx Agnt Add	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
61736	LITT ICR 1 TRAJ 1 SMPL LES	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
61737	LITT ICR MLT TRJ MLT/CPLX LS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
62263	EPIDURAL LYSIS MULT SESSIONS	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
62264	EPIDURAL LYSIS ON SINGLE DAY	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
62287	DCMPRN PX PERQ 1/MLT LUMBAR	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
64505	N Block Spenopalatine Gangl	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
64555	IMPLANT NEUROELECTRODES	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
64566	Neuroeltrd Stim Post Tibial	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
64568	OPN IMPLTJ CRNL NRV NEA&PG	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
64582	OPN MPLTJ HPGLSL NSTM ARY PG	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
64583	Rev/Rplct Hpglsl Nstm Ary Pg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
64584	Rmvl Hpglsl Nstim Ary Pg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
64590	INSRT/REDO PN/GASTR STIMUL	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
64615	Chemodenerv Musc Migraine	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
64624	DSTRJ NULYT AGT GNCLR NRV	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
64628	TRML DSTRJ IOS BVN 1ST 2 L/S	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
64629	TRML DSTRJ IOS BVN EA ADDL	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
64640	INJECTION TREATMENT OF NERVE	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
64650	Chemodenerv Eccrine Glands	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
64653	Chemodenerv Eccrine Glands	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
64802	Sympathectomy Cervical	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
64804	Remove Sympathetic Nerves	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
64809	REMOVE SYMPATHETIC NERVES	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
64818	Remove Sympathetic Nerves	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
64820	Sympathectomy Digital Artery	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
64823	Sympathectomy Supfc Palmar	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
64999	UNLISTED PX NERVOUS SYSTEM	Unlisted Procedure; May require Prior Authorization per contract agreement.	–	–	–
65710	Corneal Transplant	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
65730	Corneal Transplant	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
65750	Corneal Transplant	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
65755	Corneal Transplant	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
65756	Corneal Trnspl Endothelial	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
65757	Prep Corneal Endo Allograft	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
65760	REVISION OF CORNEA	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
65765	Revision Of Cornea	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
65767	CORNEAL TISSUE TRANSPLANT	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
65770	REVISE CORNEA WITH IMPLANT	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
65771	Radial Keratotomy	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
65772	CORRECTION OF ASTIGMATISM	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
65775	CORRECTION OF ASTIGMATISM	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
65778	Cover Eye W/Membrane	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
65785	IMPLTJ NTRSTRML CRNL RNG SEG	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–

66174	TRLUML DIL AQ O/F CAN W/O ST	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
66175	TRLUML DIL AQ O/F CAN W/ST	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
66179	AQUEOUS SHUNT EYE W/O GRAFT	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
66180	AQUEOUS SHUNT EYE W/GRAFT	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
66183	INSERT ANT DRAINAGE DEVICE	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
66184	Revision Of Aqueous Shunt	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
66185	Revise Aqueous Shunt Eye	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
66989	XCPSL CTRC RMVL CPLX INSJ 1+	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
66991	XCAPSL CTRC RMVL INSJ 1+	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
66999	UNLISTED PX ANT SEGMENT EYE	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
67027	Implant Eye Drug System	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
67028	Injection Eye Drug	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
67221	Ocular Photodynamic Ther	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
67225	Eye Photodynamic Ther Add-On	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
67299	UNLISTED PX POSTERIOR SEGMNT	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
67399	UNLISTED PX EXTRAOCULAR MUSC	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
67599	UNLISTED PROCEDURE ORBIT	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
67901	REPAIR EYELID DEFECT	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
67902	REPAIR EYELID DEFECT	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
67903	REPAIR EYELID DEFECT	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
67904	REPAIR EYELID DEFECT	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
67906	REPAIR EYELID DEFECT	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
67908	REPAIR EYELID DEFECT	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
67999	UNLISTED PROCEDURE EYELIDS	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
68399	UNLISTED PX CONJUNCTIVA	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
68899	UNLISTED PX LACRIMAL SYSTEM	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
69090	PIERCE EARLOBES	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
69300	REVISE EXTERNAL EAR	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
69399	UNLISTED PX EXTERNAL EAR	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
69676	Remove Middle Ear Nerve	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
69705	NPS SURG DILAT EUST TUBE UNI	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
69706	NPS SURG DILAT EUST TUBE BI	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
69716	IMPL OI IMPLT SK TC ESP<100	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
69719	RPLCM OI IMPLT SK TC ESP<100	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
69728	RMV NTR OI IMP SK TC>=100	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	1/1/2023	–	Add effective 01/01/2023
69729	IMPL OI IMPLT SK TC ESP>=100	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	1/1/2023	–	Add effective 01/01/2023
69730	RPLC OI IMPLT SK TC ESP>=100	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	1/1/2023	–	Add effective 01/01/2023
69799	UNLISTED PX MIDDLE EAR	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
69949	UNLISTED PX INNER EAR	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
69979	UNLISTED PX TEMPORAL BONE	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
75894	X-Rays Transcath Therapy	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
75956	Xray Endovasc Thor Ao Repr	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
75957	Xray Endovasc Thor Ao Repr	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
75958	Xray Place Prox Ext Thor Ao	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
75959	Xray Place Dist Ext Thor Ao	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
76120	CINE/VIDEO X-RAYS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
76125	CINE/VIDEO X-RAYS ADD-ON	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
76496	UNLISTED FLUOROSCOPIC PX	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
76497	UNLISTED CT PROCEDURE	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
76498	UNLISTED MR PROCEDURE	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
76499	UNLISTED DX RADIOGRAPHIC PX	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
76940	US GUIDE TISSUE ABLATION	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
76948	Echo Guide Ova Aspiration	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
76999	ECHO EXAMINATION PROCEDURE	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–

77013	Ct Guide For Tissue Ablation	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
77299	UNLISTED PX THER RAD TX PLNG	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
77399	UNLISTED PX MED RADJ PHYSICS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
77499	UNLISTED PX THER RAD TX MGMT	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
77799	UNLISTED PX CLIN BRACHYTX	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
78099	UNLISTED ENDOCRINE PX DX NUC	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
78199	UNLSTD HEMATOP RET/ENDO LYMP	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
78299	UNLISTED GI PX DX NUC MED	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
78399	UNLISTED MUSCSKEL PX DX NUC	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
78434	Aqmbf Pet Rest & Rx Stress	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
78499	UNLISTED CV PX DX NUC MED	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
78599	UNLISTED RESP PX DX NUC MED	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
78699	UNLISTED NRVS SYS PX DX NUC	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
78799	UNLISTED GU PX DX NUC MED	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
78999	UNLISTED MISC PX DX NUC MED	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
79445	Nuclear Rx Intra-Arterial	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
79999	RP THERAPY UNLISTED PX	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
80299	QUANTITATIVE ASSAY DRUG	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
81099	UNLISTED URINALYSIS PX	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
81161	Dmd Dup/Delet Analysis	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
81206	Bcr/Abl1 Gene Major Bp	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
81207	Bcr/Abl1 Gene Minor Bp	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
81241	F5 Gene	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
81243	Fmr1 Gene Detection	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
81420	Fetal Chrmoml Aneuploidy	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
81479	UNLISTED MOLECULAR PATHOLOGY	Unlisted Procedure; May require Prior Authorization per contract agreement.	_	_	_
81490	Autoimmune Rheumatoid Arthr	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
81503	Onco (Ovar) Five Proteins	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
81507	Fetal Aneuploidy Trisom Risk	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
81535	Oncology Gynecologic	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
81536	Oncology Gynecologic	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
81538	Oncology Lung	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
81539	Oncology Prostate Prob Score	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
81599	UNLISTED MAAA	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
82523	COLLAGEN CROSSLINKS	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
82777	Galectin-3	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
83006	Growth Stimulation Gene 2	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
83695	ASSAY OF LIPOPROTEIN(A)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
83698	ASSAY LIPOPROTEIN PLA2	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
83701	LIPOPROTEIN BLD HR FRACTION	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
83704	LIPOPROTEIN BLD QUAN PART	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
83722	LIPOPRTN DIR MEAS SD LDL CHL	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
83937	ASSAY OF OSTEOCALCIN	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
83987	EXHALED BREATH CONDENSATE	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
84112	EVAL AMNIOTIC FLUID PROTEIN	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
84431	THROMBOXANE URINE	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
84999	UNLISTED CHEMISTRY PROCEDURE	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
85999	UNLISTED HEMATOLOGY&COAGJ PX	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
86001	ALLERGEN SPECIFIC IGG	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
86343	LEUKOCYTE HISTAMINE RELEASE	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
86352	Cell Function Assay W/Stim	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

86353	LYMPHOCYTE TRANSFORMATION	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
86486	SKIN TEST UNLISTED ANTIGN EA	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
86849	IMMUNOLOGY PROCEDURE	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
86910	BLOOD TYPING PATERNITY TEST	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
86950	Leukacyte Transfusion	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
86999	UNLISTED TRANSFUSION MED PX	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
87505	NFCT AGENT DETECTION GI	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
87506	IADNA-DNA/RNA PROBE TQ 6-11	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
87507	IADNA-DNA/RNA PROBE TQ 12-25	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
87797	DETECT AGENT NOS DNA DIR	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
87798	DETECT AGENT NOS DNA AMP	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
87799	DETECT AGENT NOS DNA QUANT	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
87899	AGENT NOS ASSAY W/OPTIC	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
87999	UNLISTED MICROBIOLOGY PX	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
88099	UNLISTED NECROPSY (AUTOPSY)	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
88199	UNLISTED CYTOPATHOLOGY PX	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
88299	UNLISTED CYTOGENETIC STUDY	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
88375	OPTICAL ENDOMICROSCPY INTERP	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
88399	UNLISTED SURGICAL PATH PX	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
88749	UNLISTED IN VIVO LAB SERVICE	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
89240	UNLISTED MISC PATH TEST	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
89250	Cultr Oocyte/Embryo <4 Days	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
89251	Cultr Oocyte/Embryo <4 Days	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
89253	Embryo Hatching	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
89254	Oocyte Identification	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89255	Prepare Embryo For Transfer	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89257	Sperm Identification	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89258	CRYOPRESERVATION EMBRYO(S)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89259	CRYOPRESERVATION SPERM	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89260	Sperm Isolation Simple	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89261	Sperm Isolation Complex	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89264	Identify Sperm Tissue	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89268	Insemination Of Oocytes	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89272	Extended Culture Of Oocytes	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89280	Assist Oocyte Fertilization	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89281	Assist Oocyte Fertilization	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89290	Biopsy Oocyte Polar Body	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
89291	Biopsy Oocyte Polar Body	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
89325	Sperm Antibody Test	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89329	Sperm Evaluation Test	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89330	Evaluation Cervical Mucus	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89331	Retrograde Ejaculation Anal	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89335	CRYOPRESERVE TESTICULAR TISS	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89337	CRYOPRESERVATION OOCYTE(S)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89342	STORAGE/YEAR EMBRYO(S)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89343	STORAGE/YEAR SPERM/SEMEN	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89344	STORAGE/YEAR REPROD TISSUE	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89346	STORAGE/YEAR OOCYTE(S)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89352	THAWING CRYOPRESRVED EMBRYO	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89353	THAWING CRYOPRESRVED SPERM	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89354	THAW CRYOPRSVRD REPROD TISS	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89356	THAWING CRYOPRESRVED OOCYTE	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89398	UNLISTED REPROD MED LAB PROC	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
90283	HUMAN IG IV	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
90284	HUMAN IG SC	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
90378	RSV MAB IM 50MG	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
90399	UNLISTED IMMUNE GLOBULIN	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
90584	Dengue Vacc Quad 2 Dose Subq	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
90626	Tic-Brn Enceph Vac 0.25Ml Im	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
90627	Tic-Brn Enceph Vac 0.5Ml Im	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
90664	Laiv Vacc Pandemic Intranasl	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
90666	FLU VAC PANDEM PRSRV FREE IM	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
90667	IIV VACC PANDEMIC ADJUVT IM	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

90678	RSV VACC PREF BIVALENT IM	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2023	_	Add effective 01/01/2023
90749	UNLISTED VACCINE/TOXOID	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
90759	BIT095_NON_COVERED.csv	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
90867	TCRANIAL MAGN STIM TX PLAN	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
90868	TCRANIAL MAGN STIM TX DELI	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
90869	TCRAN MAGN STIM REDETEMINE	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
90870	ELECTROCONVULSIVE THERAPY	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
90875	PSYCHOPHYSIOLOGICAL THERAPY	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
90876	PSYCHOPHYSIOLOGICAL THERAPY	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
90880	HYPNOTHERAPY	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
90885	PSY EVALUATION OF RECORDS	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
90889	PREPARATION OF REPORT	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
90899	UNLISTED PSYC SVC/THERAPY	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
90901	BIOFEEDBACK TRAIN ANY METH	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
90912	BFB TRAINING 1ST 15 MIN	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
90913	BFB TRAINING EA ADDL 15 MIN	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
90999	UNLISTED DIALYSIS PROCEDURE	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
91034	Gastroesophageal Reflux Test	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
91035	G-Esoph Reflx Tst W/Electrod	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
91037	Esoph Imped Function Test	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
91038	Esoph Imped Funct Test > 1Hr	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
91065	BREATH HYDROGEN/METHANE TEST	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
91110	GI TRC IMG INTRAL ESOPH-ILE	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
91111	GI TRC IMG INTRAL ESOPHAGUS	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
91112	GI WIRELESS CAPSULE MEASURE	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
91113	GI TRC IMG INTRAL COLON I&R	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	1/1/2023	_	Add effective 01/01/2023
91117	Colon Motility 6 Hr Study	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
91132	ELECTROGASTROGRAPHY	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
91133	ELECTROGASTROGRAPHY W/TEST	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
91299	UNLISTED DX GI PROCEDURE	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
92065	ORTHOP TRAING PFRMD PHYS/QHP	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
92066	ORTHOP TRAING SUPVJ PHYS/QHP	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
92132	CMPTR OPHTH DX IMG ANT SEGMT	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
92145	CORNEAL HYSTERESIS DETER	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
92273	Full Field Erg W/I&R	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
92274	Multifocal Erg W/I&R	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
92499	UNLISTED OPH SVC/PROCEDURE	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
92512	NASAL FUNCTION STUDIES	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
92517	VEMP TEST I&R CERVICAL	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
92518	VEMP TEST I&R OCULAR	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
92519	VEMP TST I&R CERVICAL&OCULAR	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
92520	Laryngeal Function Studies	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
92548	CDP-SOT 6 COND W/I&R	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
92549	CDP-SOT 6 COND W/I&R MCT&ADT	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
92601	Cochlear Implt F/Up Exam <7	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
92602	Reprogram Cochlear Implt <7	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
92603	Cochlear Implt F/Up Exam 7/>	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
92640	Aud Brainstem Implt Programg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
92700	UNLISTED ORL SERVICE/PX	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
92971	Cardioassist External	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
92974	Cath Place Cardio Brachytx	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
92978	Endoluminl Ivus Oct C 1St	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
92979	Endoluminl Ivus Oct C Ea	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

93025	Microvolt T-Wave Assess	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
93050	ART PRESSURE WAVEFORM ANALYS	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
93228	REMOTE 30 DAY ECG REV/REPORT	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
93229	REMOTE 30 DAY ECG TECH SUPP	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
93260	Prgrmg Dev Eval Impltbl Sys	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
93261	Interrogate Subq Defib	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
93264	REM MNTR WRLS P-ART PRS SNR	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
93278	Ecg/Signal-Averaged	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
93356	Myocrd Strain Img Spckl Trck	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
93580	TRANSCATH CLOSURE OF ASD	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
93640	Evaluation Heart Device	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
93641	Electrophysiology Evaluation	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
93642	Electrophysiology Evaluation	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
93644	Electrophysiology Evaluation	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
93660	TILT TABLE EVALUATION	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
93701	Bioimpedance Cv Analysis	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
93702	BIS XTRACELL FLUID ANALYSIS	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
93740	TEMPERATURE GRADIENT STUDIES	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
93797	Cardiac Rehab	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
93798	Cardiac Rehab/Monitor	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
93799	UNLISTED CV SVC/PROCEDURE	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
93886	Intracranial Complete Study	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
93888	Intracranial Limited Study	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
93890	Tcd Vasoreactivity Study	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
93892	Tcd Emboli Detect W/O Inj	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
93893	Tcd Emboli Detect W/Inj	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
93998	UNLISTD NONINVAS VASC DX STD	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
94014	PATIENT RECORDED SPIROMETRY	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
94015	PATIENT RECORDED SPIROMETRY	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
94016	REVIEW PATIENT SPIROMETRY	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
94669	Mechanical Chest Wall Oscill	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
94774	Ped Home Apnea Rec Compl	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
94775	Ped Home Apnea Rec Hk-Up	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
94776	Ped Home Apnea Rec Downld	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
94777	Ped Home Apnea Rec Report	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
94799	UNLISTED PULMONARY SVC/PX	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
95027	Icut Allergy Titrate-Airborn	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95060	EYE ALLERGY TESTS	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
95065	NOSE ALLERGY TEST	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
95199	UNLISTED ALL/IMMLG SVC/PX	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
95700	Eeg Cont Rec W/Vid Eeg Tech	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95705	Eeg W/O Vid 2-12 Hr Unmntr	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95706	Eeg Wo Vid 2-12Hr Intmt Mntr	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95707	Eeg W/O Vid 2-12Hr Cont Mntr	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95708	Eeg Wo Vid Ea 12-26Hr Unmntr	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95709	Eeg W/O Vid Ea 12-26Hr Intmt	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95710	Eeg W/O Vid Ea 12-26Hr Cont	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95711	Veeg 2-12 Hr Unmonitored	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95712	Veeg 2-12 Hr Intmt Mntr	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95713	Veeg 2-12 Hr Cont Mntr	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95714	Veeg Ea 12-26 Hr Unmntr	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–

95715	Veeg Ea 12-26Hr Intmt Mntr	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95716	Veeg Ea 12-26Hr Cont Mntr	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95717	Eeg Phys/Qhp 2-12 Hr W/O Vid	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95718	Eeg Phys/Qhp 2-12 Hr W/Veeg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95719	Eeg Phys/Qhp Ea Incr W/O Vid	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95720	Eeg Phy/Qhp Ea Incr W/Veeg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95721	Eeg Phy/Qhp>36<60 Hr W/O Vid	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95722	Eeg Phy/Qhp>36<60 Hr W/Veeg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95723	Eeg Phy/Qhp>60<84 Hr W/O Vid	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95724	Eeg Phy/Qhp>60<84 Hr W/Veeg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95725	Eeg Phy/Qhp>84 Hr W/O Vid	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95726	Eeg Phy/Qhp>84 Hr W/Veeg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95782	Polysom <6 Yrs 4/> Paramtrs	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95783	Polysom <6 Yrs Cpap/Bilvl	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95803	ACTIGRAPHY TESTING	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95805	MULTIPLE SLEEP LATENCY TEST	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95807	SLEEP STUDY ATTENDED	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95808	POLYSOM ANY AGE 1-3> PARAM	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95810	Polysom 6/> Yrs 4/> Param	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95811	Polysom 6/>Yrs Cpap 4/> Parm	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95905	MOTOR &/ SENS NRVE CNDJ TEST	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
95919	QUAN PUPLMTRY PHY/QHP UNI/BI	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	1/1/2023	–	Add effective 01/01/2023
95954	Eeg Monitoring/Giving Drugs	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95957	Eeg Digital Analysis	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95961	Electrode Stimulation Brain	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95962	Electrode Stim Brain Add-On	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95965	MEG SPONTANEOUS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95966	MEG EVOKED SINGLE	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95967	MEG EVOKED EACH ADDL	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95970	Alys Npgt W/O Prgrmg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95971	Alys Smpl Sp/Pn Npgt W/Prgrm	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95972	Alys Cplx Sp/Pn Npgt W/Prgrm	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95976	Alys Smpl Cn Npgt Prgrmg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95977	Alys Cplx Cn Npgt Prgrmg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95981	IO ANAL GAST N-STIM SUBSQ	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95982	IO GA N-STIM SUBSQ W/REPROG	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95983	Alys Brn Npgt Prgrmg 15 Min	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95984	Alys Brn Npgt Prgrmg Addl 15	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
95999	UNLISTED NEUROLOGICAL DX PX	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
96000	MOTION ANALYSIS VIDEO/3D	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
96001	MOTION TEST W/FT PRESS MEAS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
96002	DYNAMIC SURFACE EMG	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
96003	DYNAMIC FINE WIRE EMG	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
96004	PHYS REVIEW OF MOTION TESTS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
96379	UNL THER/PROP/DIAG INJ/INF	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
96549	UNLISTED CHEMOTHERAPY PX	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
96567	Pdt Dstr Prmlg Les Skn	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
96570	Photodynmc Tx 30 Min Add-On	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
96571	PHOTODYNAMIC TX ADDL 15 MIN	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
96573	Pdt Dstr Prmlg Les Phys/Qhp	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
96574	Dbrdmt Prmlg Les W/Pdt	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–

96912	PHOTOCHEMOTHERAPY WITH UV-A	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
96913	PHOTOCHEMOTHERAPY UV-A OR B	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
96922	Laser Tx Skin >500 Sq Cm	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
96931	Rcm Celulr Subcelulr Img Skn	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
96932	Rcm Celulr Subcelulr Img Skn	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
96933	Rcm Celulr Subcelulr Img Skn	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
96934	Rcm Celulr Subcelulr Img Skn	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
96935	Rcm Celulr Subcelulr Img Skn	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
96936	Rcm Celulr Subcelulr Img Skn	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
96999	UNLISTED SPEC DERM SVC/PX	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
97012	Mechanical Traction Therapy	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
97014	Electric Stimulation Therapy	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
97024	Diathermy Eg Microwave	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
97032	Electrical Stimulation	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
97039	UNLISTED MODALITY	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
97124	Massage Therapy	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
97139	UNLISTED THERAPEUTIC PX	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
97169	Athletic Trn Eval Low Cmplx	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
97170	Athletic Trn Eval Mod Cmplx	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
97171	Athletic Trn Eval High Cmplx	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
97172	Athletic Trn Re-Eval Plan Cr	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
97533	Sensory Integration	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
97537	Community/Work Reintegration	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
97545	Work Hardening	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
97546	Work Hardening Add-On	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
97605	Neg Press Wound Tx <=50 Cm	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
97606	Neg Press Wound Tx >50 Cm	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
97607	Neg Press Wnd Tx <=50 Sq Cm	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
97608	Neg Press Wound Tx >50 Cm	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
97610	LOW FREQUENCY NON-THERMAL US	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
97799	UNLISTED PHYSCL MED/REHAB PX	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
97810	ACUPUNCT W/O STIMUL 15 MIN	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
97811	ACUPUNCT W/O STIMUL ADDL 15M	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
97813	ACUPUNCT W/STIMUL 15 MIN	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
97814	ACUPUNCT W/STIMUL ADDL 15M	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
98962	Self-Mgmt Educ/Train 5-8 Pt	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
99026	IN-HOSPITAL ON CALL SERVICE	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
99027	OUT-OF-HOSP ON CALL SERVICE	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
99050	MEDICAL SERVICES AFTER HRS	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
99056	MED SERVICE OUT OF OFFICE	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
99058	OFFICE EMERGENCY CARE	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
99070	SPECIAL SUPPLIES PHYS/QHP	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
99071	PATIENT EDUCATION MATERIALS	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
99075	MEDICAL TESTIMONY	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.	_	_	_
99075	MEDICAL TESTIMONY	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.	_	_	_
99078	GROUP HEALTH EDUCATION	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
99080	SPECIAL REPORTS OR FORMS	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.	_	_	_
99080	SPECIAL REPORTS OR FORMS	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.	_	_	_
99082	UNUSUAL PHYSICIAN TRAVEL	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.	_	_	_
99082	UNUSUAL PHYSICIAN TRAVEL	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.	_	_	_
99199	UNLISTED SPECIAL SVC PX/RPRT	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
99360	PHYSICIAN STANDBY SERVICES	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
99424	BIT095_NON_COVERED.csv	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
99425	BIT095_NON_COVERED.csv	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
99426	BIT095_NON_COVERED.csv	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
99427	BIT095_NON_COVERED.csv	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
99429	UNLISTED PREVENTIVE SERVICE	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
99437	BIT095_NON_COVERED.csv	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
99450	BASIC LIFE DISABILITY EXAM	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
99455	WORK RELATED DISABILITY EXAM	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
99456	DISABILITY EXAMINATION	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
99491	Chrnc Care Mgmt Svc 30 Min	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
99499	UNLISTED E&M SERVICE	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
99509	HOME VISIT DAY LIFE ACTIVITY	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

99512	Home Visit For Hemodialysis	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
99600	UNLISTED HOME VISIT SVC/PX	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
0052U	LPOPRTN BLD W/5 MAJ CLASSES	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0054T	BONE SRGRY CMPTR FLUOR IMAGE	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0055T	BONE SRGRY CMPTR CT/MRI IMAG	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0062U	AI SLE IGG&IGM ALYS 80 BMRK	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0063U	NEURO AUTISM 32 AMINES ALG	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0066U	PAMG-1 IA CERVICO-VAG FLUID	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0071T	Us Leiomyomata Ablate <200	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0072T	Us Leiomyomata Ablate >200	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0075T	PERQ STENT/CHEST VERT ART	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0076T	S&I STENT/CHEST VERT ART	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0100T	PROSTH RETINA RECEIVE&GEN	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0101T	ESW MUSCSKEL SYS NOS	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0102T	ESW PHY ANES LAT HMRL EPCNDL	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0106T	TOUCH QUANT SENSORY TEST	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0106U	GSTR EMPTG 7 TIMED BRTH SPEC	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0107T	VIBRATE QUANT SENSORY TEST	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0108T	COOL QUANT SENSORY TEST	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0109T	HEAT QUANT SENSORY TEST	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0110T	NOS QUANT SENSORY TEST	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0175T	Cad Cxr Remote	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0184T	Exc Rectal Tumor Endoscopic	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0198T	OCULAR BLOOD FLOW MEASURE	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0200T	PERQ SACRAL AUGMT UNILAT INJ	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0201T	PERQ SACRAL AUGMT BILAT INJ	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0202T	POST VERT ARTHRPLST 1 LUMBAR	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0207T	CLEAR EYELID GLAND W/HEAT	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0208T	Audiometry Air Only	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0209T	Audiometry Air & Bone	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0210T	Speech Audiometry Threshold	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0211T	Speech Audiom Thresh & Recog	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0219T	PLMT POST FACET IMPLT CERV	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0220T	PLMT POST FACET IMPLT THOR	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0221T	PLMT POST FACET IMPLT LUMB	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0222T	PLMT POST FACET IMPLT ADDL	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0232T	NJX PLATELET PLASMA	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0253T	INSERT AQUEOUS DRAIN DEVICE	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0263T	IM B1 MRW CEL THER CMPL	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0264T	IM B1 MRW CEL THER XCL HRVST	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0265T	IM B1 MRW CEL THER HRVST ONL	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0266T	IMPLT/RPL CRTD SNS DEV TOTAL	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0267T	IMPLT/RPL CRTD SNS DEV LEAD	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0268T	IMPLT/RPL CRTD SNS DEV GEN	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0269T	REV/REMVL CRTD SNS DEV TOTAL	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0270T	REV/REMVL CRTD SNS DEV LEAD	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0271T	REV/REMVL CRTD SNS DEV GEN	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0272T	INTERROGATE CRTD SNS DEV	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0273T	INTERROGATE CRTD SNS W/PGRMG	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0274T	PERQ LAMOT/LAM CRV/THRC	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–

0275T	PERQ LAMOT/LAM LUMBAR	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0278T	TEMPR	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0308T	INSJ OCULAR TELESCOPE PROSTH	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0323U	Iadna Cns Pthgn Next Gen Seq	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0324U	Onc Ovar Sphrd Cell 4 Rx Pnl	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0325U	Onc Ovar Sphrd Cell Parp	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0329T	Mntr Io Press 24Hrs/> Uni/Bi	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0330T	TEAR FILM IMG UNI/BI W/I&R	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0331T	HEART SYMP IMAGE PLNR	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0332T	HEART SYMP IMAGE PLNR SPECT	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0332U	ONC PAN TUM GEN PRFLG 8 DNA	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0333U	ONC LVR SURVEILANC HCC CFDNA	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0334U	ONC SLD ORGN TGSA DNA 84/+	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0335T	INSJ SINUS TARSI IMPLANT	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0335U	RARE DS WHL GEN SEQ FETAL	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0336U	RARE DS WHL GEN SEQ BLD/SLV	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0337U	ONC PLSM CELL DOandMYELOMA ID	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0338T	TRNSCTH RENAL SYMP DENRV UNL	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0338U	ONC SLD TUM CRCG TUM CL SLCT	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0339T	TRNSCTH RENAL SYMP DENRV BIL	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0339U	ONC PRST8 MRNA HOXC6 and DLX1	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0340U	ONC PAN CA ALYS MRD PLASMA	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0341U	FTL ANEUP DNA SEQ CMPR ALYS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0342T	Thxp Apheresis W/Hdl Delip	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0342U	ONC PNCRTC CA MULT IA ECLIA	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0343U	ONC PRST8 XOM ALY 442 SNCRNA	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0344U	HEP NAFLD SEMIQ EVL 28 LIPID	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0345T	TRANSCATH MTRAL VLVE REPAIR	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0345U	PSYC GENOM ALYS PNL 15 GEN	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0346U	BETA AMYL A?40andA?42 LC-MS/MS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0347T	INS BONE DEVICE FOR RSA	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0347U	RX METAB/PCX DNA 16 GEN ALYS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0348T	RSA SPINE EXAM	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0348U	RX METAB/PCX DNA 25 GEN ALYS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0349T	RSA UPPER EXTR EXAM	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0349U	RX METAB/PCX DNA 27GEN RX IA	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0350T	RSA LOWER EXTR EXAM	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0350U	RX METAB/PCX DNA 27 GEN ALYS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0351T	Intraop Oct Brst/Node Spec	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0351U	NFCT DS BCT/VIRAL TRAIL IP10	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0352T	OCT BRST/NODE I&R PER SPEC	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0352U	NFCT DS BVandVAGINITIS AMP PRB	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0353T	Intraop Oct Breast Cavity	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0353U	IADNA CHLMYDandGONORR AMP PRB	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0354U	HPV HI RSK QUAL MRNA E6/E7	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0358T	BIA WHOLE BODY	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0378T	VISUAL FIELD ASSMNT REV/RPRT	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0379T	VIS FIELD ASSMNT TECH SUPPT	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0397T	ERCP W/OPTICAL ENDOMICROSCPY	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0402T	COLGN CRS-LINK CRN&PACHYMTRY	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–

0408T	Insj/Rplc Cardiac Modulj Sys	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0409T	Insj/Rplc Car Modulj Pls Gn	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0410T	Insj/Rplc Car Modulj Atr Elt	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0411T	Insj/Rplc Car Modulj Vnt Elt	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0412T	Rmvl Cardiac Modulj Pls Gen	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0413T	Rmvl Car Modulj Tranvns Elt	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0414T	Rmvl & Rpl Car Modulj Pls Gn	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0415T	Repos Car Modulj Tranvns Elt	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0416T	Reloc Skin Pocket Pls Gen	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0417T	Prgrmg Eval Cardiac Modulj	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0418T	Interro Eval Cardiac Modulj	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0419T	Dstrj Neurofibroma Xtnsv	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0420T	Dstrj Neurofibroma Xtnsv	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0421T	WATERJET PROSTATE ABLTJ CMPL	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	2/28/2023	Remove effective 02/28/2023
0422T	TACTILE BREAST IMG UNI/BI	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0424T	INSJ/RPLC NSTIM APNEA COMPL	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0425T	INSJ/RPLC NSTIM APNEA SEN LD	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0426T	INSJ/RPLC NSTIM APNEA STM LD	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0427T	INSJ/RPLC NSTIM APNEA PLS GN	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0428T	RMVL NSTIM APNEA PLS GEN	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0429T	RMVL NSTIM APNEA SEN LD	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0430T	RMVL NSTIM APNEA STIMJ LD	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0431T	RMVL/RPLC NSTIM APNEA PLS GN	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0432T	REPOS NSTIM APNEA STIMJ LD	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0433T	REPOS NSTIM APNEA SENSING LD	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0434T	INTERRO EVAL NPGS APNEA	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0435T	PRGRMG EVAL NPGS APNEA 1 SES	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0436T	PRGRMG EVAL NPGS APNEA STUDY	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0440T	Abltj Perc Uxtr/Perph Nrv	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0441T	Abltj Perc Lxtr/Perph Nrv	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0442T	Abltj Perc Plex/Trncl Nrv	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0443T	R-T Spctrl Alys Prst8 Tiss	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0449T	INSJ AQUEOUS DRAIN DEV 1ST	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0450T	INSJ AQUEOUS DRAIN DEV EACH	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0464T	VISUAL EP TEST FOR GLAUCOMA	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0465T	SUPCHRDL NJX RX W/O SUPPLY	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0472T	PRGRMG IO RTA ELTRD RA	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0473T	REPRGRMG IO RTA ELTRD RA	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0474T	INSJ AQUEOUS DRG DEV IO RSVR	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0481T	Njx Autol Wbc Concentrate	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0483T	TMVI PERCUTANEOUS APPROACH	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0484T	TMVI TRANSTHORACIC EXPOSURE	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0485T	OCT MID EAR I&R UNILATERAL	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0486T	OCT MID EAR I&R BILATERAL	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0489T	Regn Cell Tx Scldr Hands	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0490T	Regn Cell Tx Scldr H Mlt Inj	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0494T	PREP & CANNULJ CDVR DON LUNG	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0495T	MNTR CDVR DON LNG 1ST 2 HRS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0496T	MNTR CDVR DON LNG EA ADDL HR	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0507T	NEAR IFR 2IMG MIBMN GLND I&R	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–

0508T	PLS ECHO US B1 DNS MEAS TIB	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0509T	PATTERN ERG W/I&R	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0510T	Rmvl Sinus Tarsi Implant	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0511T	RMVL&RINSJ SINUS TARSI IMPLT	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0512T	ESW INTEG WND HLG 1ST WND	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0513T	ESW INTEG WND HLG EA ADDL	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0515T	Insj Wcs Lv Compl Sys	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0516T	INSJ WCS LV ELTRD ONLY	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0517T	INSJ WCS LV PG COMPNT	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0518T	Rmvl Pg Compnt Wcs	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0519T	Rmvl & Rplcmt Pg Compnt Wcs	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0520T	Rmvl&Rplcmt Pg Wcs New Eltrd	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0521T	Interrog Dev Eval Wcs Ip	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0522T	Prgrmg Dev Eval Wcs Ip	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0524T	EV CATH DIR CHEM ABLTJ W/IMG	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0525T	Insj/Rplcmt Compl Iims	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0526T	Insj/Rplcmt Iims Eltrd Only	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0527T	Insj/Rplcmt Iims Implt Mntr	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0528T	Prgrmg Dev Eval Iims Ip	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0529T	INTERROG DEV EVAL IIMS IP	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0530T	Removal Complete Iims	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0531T	Removal Iims Electrode Only	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0532T	Removal Iims Implt Mntr Only	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0533T	CONT REC MVMT DO 6-10 DAYS	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0534T	CONT REC MVMT DO SETUP&TRAIN	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0535T	CONT REC MVMT DO REPRT CNFIG	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0536T	CONT REC MVMT DO DL W/I&R	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0537T	Bld Drv T Lymphcyt Car-T Cll	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0538T	Bld Drv T Lymphcyt Prep Trns	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0539T	Receipt&Prep Car-T Cll Admn	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0540T	Car-T Cll Admn Autologous	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0544T	TCAT MV ANNULUS RCNSTJ	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0547T	B1 Matrl Qual Tst Mcrind Tib	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
0552T	LOW-LEVEL LASER THERAPY	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0563T	EVAC MEIBOMIAN GLND HEAT BI	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0565T	AUTOL CELL IMPLT ADPS HRVG	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0566T	AUTOL CELL IMPLT ADPS NJX	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0587T	PERQ IMPLTJ/RPLCMT ISDNS PTN	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0588T	REVISION/REMOVAL ISDNS PTN	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0589T	ELEC ALYS SMPL PRGRMG IINS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0590T	ELEC ALYS CPLX PRGRMG IINS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0602T	TRANSDERMAL GFR MEASUREMENTS	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0603T	TRANSDERMAL GFR MONITORING	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0615T	EYE MVMT ALYS W/O CALBRJ I&R	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0620T	EVASC VEN ARTLZ TIBL/PRNL VN	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0621T	TRABECULOSTOMY INTERNO LASER	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0622T	TRABECULOSTOMY INT LSR W/SCP	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0623T	AUTO QUANTIFICATION C PLAQUE	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0624T	AUTO QUAN C PLAQ DATA PREP	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0625T	AUTO QUAN C PLAQ CPTR ALYS	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–

0626T	AUTO QUAN C PLAQ I&R	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0627T	PERQ NJX ALGC FLUOR LMBR 1ST	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0628T	PERQ NJX ALGC FLUOR LMBR EA	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0629T	PERQ NJX ALGC CT LMBR 1ST	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0630T	PERQ NJX ALGC CT LMBR EA	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0631T	TC VIS LIT HYPERSPECTRAL IMG	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0632T	PERQ TCAT US ABLTJ NRV P-ART	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0639T	WRLS SKN SNR ANISOTROPY MEAS	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0640T	NCNTC NR IFR SPCTRSC WND	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0641T	NCNTC NR IFR SPCTRSC WND IMG	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0642T	NCNTC NR IFR SPCTRSC WND I&R	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0643T	TCAT L VENTR RSTRJ DEV IMPLT	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0645T	TCAT IMPLTJ C SINS RDCTJ DEV	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0646T	TTVI/RPLCMT W/PRSTC VLV PERQ	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0650T	PRGRMG DEV EVAL SCRMS REMOTE	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0651T	MAG CTRLD CAPSULE ENDOSCOPY	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	1/1/2023	–	Add effective 01/01/2023
0656T	VRT BDY TETHERING ANT <7 SEG	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0657T	VRT BDY TETHERING ANT 8+ SEG	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0658T	Elec Impd Spectrsc 1+Skn Les	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0664T	DON HYSTERECTOMY OPEN CDVR	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0665T	DON HYSTERECTOMY OPEN LIV	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0666T	DON HYSTERECTOMY LAPS LIV	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0667T	DON HYSTERECTOMY RCP UTER	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0668T	BKBENCH PREP DON UTER ALGRFT	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0669T	BKBENCH RCNSTJ DON UTER VEN	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0670T	BKBENCH RCNSTJ DON UTER ARTL	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0672T	NDOVAG CRYG RF REMDL TISS	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
0714T	Tprnl Lsr Ablt B9 Prst8 Hypr	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0715T	Perq Trluml Coronry Lithotrp	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0716T	Car Acous Wavfrm Rec Cad Rsk	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0717T	Adrc Ther Prtl Rc Tear	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0718T	Adrc Ther Prtl Rc Tear Njx	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0719T	Pst Vrt Jt Rplcmt Lmbr 1 Sgm	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0720T	Prq Elc Nrv Stim Cn Wo Implt	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0721T	Quan Ct Tiss Charac W/O Ct	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0722T	Quan Ct Tiss Charac W/Ct	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0723T	Qmrcp W/O Dx Mri Sm Anat Ses	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0724T	Qmrcp W/Dx Mri Same Anatomy	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0725T	Vestibular Dev Impltj Uni	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0726T	Rmvl Implt Vstibular Dev Uni	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0727T	Rmvlandrplcmt Implt Vstblr Dev	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0728T	Dx Alys Vstblr Implt Uni 1St	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0729T	Dx Alys Vstblr Implt Uni Sbq	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0730T	Trabeculotomy Lsr W/Oct Gdn	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0731T	Augmnt Ai-Based Fcl Phnt A/R	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0732T	Immntx Admn Electroporatn Im	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0733T	Rem Bdyandlmb Knmtc Ther Sply	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0734T	Rem Bdyandlmb Knmtc Tx Mgmt	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0735T	Prep Tum Cav Iort Prim Crnot	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
0737T	Xenograft Impltj Artclr Surf	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–

0743T	B1 STR & FX RSK VRT FX ASSMT	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	1/1/2023	_	Add effective 01/01/2023
0775T	ARTHRD SI JT PRQ IARTIC IMPL	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	1/1/2023	_	Add effective 01/01/2023
0780T	INSTLJ FECAL MICROBIOTA SSP	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	1/1/2023	_	Add effective 01/01/2023
0783T	TC AURICULR NEUROSTIMULATION	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	1/1/2023	_	Add effective 01/01/2023
0791T	Motor-cognitive, semi-immersive virtual reality–facilitated gait training, each 15 minutes (List separately in addition to code for primary procedure)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	7/1/2023	_	Add effective 07/01/2023
0793T	Percutaneous transcatheter thermal ablation of nerves innervating the pulmonary arteries, including right heart catheterization, pulmonary artery angiography, and all imaging guidance	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	7/1/2023	_	Add effective 07/01/2023
0795T	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; complete system (i.e., right atrial and right ventricular pacemaker components)	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	7/1/2023	_	Add effective 07/01/2023
0796T	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; right atrial pacemaker component (when an existing right ventricular single leadless pacemaker exists to create a dual-chamber leadless pacemaker system)	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	7/1/2023	_	Add effective 07/01/2023
0797T	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	7/1/2023	_	Add effective 07/01/2023
0798T	Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; complete system (i.e., right atrial and right ventricular pacemaker components)	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	7/1/2023	_	Add effective 07/01/2023
0799T	Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; right atrial pacemaker component	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	7/1/2023	_	Add effective 07/01/2023
0800T	Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	7/1/2023	_	Add effective 07/01/2023
0801T	Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; dual-chamber system (i.e., right atrial and right ventricular pacemaker components)	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	7/1/2023	_	Add effective 07/01/2023

0802T	Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; right atrial pacemaker component	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	7/1/2023	_	Add effective 07/01/2023
0803T	Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	7/1/2023	_	Add effective 07/01/2023
0804T	Programming device evaluation (in person) with iterative adjustment of implantable device to test the function of device and to select optimal permanent programmed values, with analysis, review, and report, by a physician or other qualified health care professional, leadless pacemaker system in dual cardiac chambers	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	7/1/2023	_	Add effective 07/01/2023
0805T	Transcatheter superior and inferior vena cava prosthetic valve implantation (i.e., caval valve implantation [CAVI]); percutaneous femoral vein approach	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	7/1/2023	_	Add effective 07/01/2023
0806T	Transcatheter superior and inferior vena cava prosthetic valve implantation (i.e., caval valve implantation [CAVI]); open femoral vein approach	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	7/1/2023	_	Add effective 07/01/2023
0807T	Pulmonary tissue ventilation analysis using software-based processing of data from separately captured cinefluorograph images; in combination with previously acquired computed tomography (CT) images, including data preparation and transmission, quantification of pulmonary tissue ventilation, data review, interpretation and report	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	7/1/2023	_	Add effective 07/01/2023
0808T	Pulmonary tissue ventilation analysis using software-based processing of data from separately captured cinefluorograph images; in combination with computed tomography (CT) images taken for the purpose of pulmonary tissue ventilation analysis, including data preparation and transmission, quantification of pulmonary tissue ventilation, data review, interpretation and report	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	7/1/2023	_	Add effective 07/01/2023
0810T	Subretinal injection of a pharmacologic agent, including vitrectomy and 1 or more retinotomies	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	7/1/2023	_	Add effective 07/01/2023
9701A	NON-PRESCRIPTION DRUGS	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
A0021	Outside state ambulance serv	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
A0080	Noninterest escort in non er	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
A0090	Interest escort in non er	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
A0100	Nonemergency transport taxi	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
A0110	Nonemergency transport bus	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
A0120	Noner transport mini-bus	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
A0130	Noner transport wheelch van	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
A0140	Nonemergency transport air	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
A0160	Noner transport case worker	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
A0170	Transport parking fees/tolls	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
A0180	Noner transport lodgng recip	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
A0190	Noner transport meals recip	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
A0200	Noner transport lodgng escrt	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
A0210	Noner transport meals escort	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
A0420	Ambulance Waiting Time (Als Or Bls) One Half (1/2) Hour Increments	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
A0426	Als 1	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A0427	Ambulance Service Advanced Life Support Emergency Transport Level 1 (Als1-Emergency)	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

A0428	Ambulance Service Basic Life Support Non-Emergency Transport (Bls)	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A0430	Ambulance Service Conventional Air Services Transport One Way (Fixed Wing)	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A0431	Rotary wing air transport	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A0432	Paramedic Intercept (Pi) Rural Area Transport Furnished By A Volunteer Ambulance Company Which Is Prohibited By State Law From Billing Third Party Payers	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
A0435	Fixed Wing Air Mileage Per Statute Mile	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A0436	Rotary wing air mileage	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A0888	Noncovered ambulance mileage	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
A0998	Ambulance Response And Treatment No Transport	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A0999	Unlisted ambulance service	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
A2001	Innovamatrix ac per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
A2002	Mirragen adv wnd mat per sq	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
A2004	Xcellistem 1 mg	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
A2005	Microlyte matrix per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
A2006	Novosorb synpath per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
A2007	Restrata per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
A2008	Theragenesis per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
A2009	Symphony per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
A2010	Apis per square centimeter	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
A2011	Supra sdrm per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
A2012	Suprathel per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
A2013	Innovamatrix fs per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
A2013	Innovamatrix fs per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
A2014	Omeza collag per 100 mg	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	4/1/2023	_	Add effective 04/01/2023
A2014	Omeza collag per 100 mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	3/31/2023	Retire effective 03/31/2023
A2015	Phoenix wnd mtrx per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	4/1/2023	_	Add effective 04/01/2023
A2015	Phoenix wnd mtrx per sq cm	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	3/31/2023	Retire effective 03/31/2023
A2016	Permeaderm b per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	4/1/2023	_	Add effective 04/01/2023
A2016	Permeaderm b per sq cm	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	3/31/2023	Retire effective 03/31/2023
A2017	Permeaderm glove each	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	4/1/2023	_	Add effective 04/01/2023
A2017	Permeaderm glove each	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	3/31/2023	Retire effective 03/31/2023
A2018	Permeaderm c per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	4/1/2023	_	Add effective 04/01/2023
A2018	Permeaderm c per sq cm	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	3/31/2023	Retire effective 03/31/2023
A4100	Skin sub fda clrd as dev nos	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A4238	Adju Cgm Supply Allowance	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A4335	Incontinence supply	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
A4421	Ostomy supply misc	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
A4453	Rec cath man pump enema repl	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A4458	Reusable enema bag	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
A4520	Incontinence garment anytype	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
A4553	Non-Disposable Underpads All Sizes	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
A4555	Ca tx e-stim electr/transduc	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A4575	Hyperbaric o2 chamber disps	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
A4575	Hyperbaric o2 chamber disps	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
A4595	Electrical Stimulator Supplies 2 Lead Per Month (E. G. Tens Nmes)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
A4596	Ces system monthly supp	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	4/1/2023	_	Add effective 04/01/2023
A4596	Ces system monthly supp	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	3/31/2023	Retire effective 03/31/2023
A4600	Sleeve inter limb comp dev	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A4630	Replacement Batteries Medically Necessary Transcutaneous Electrical Stimulator Owned By Patient	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_

A4638	Replacement Battery For Patient-Owned Ear Pulse Generator Each	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A4639	Infrared ht sys replcmnt pad	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
A4641	Radiopharm dx agent noc	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
A4649	Surgical supplies	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
A4660	Sphygmomanometer/Blood Pressure Apparatus With Cuff And Stethoscope	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
A4663	Blood Pressure Cuff Only	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
A4913	Misc dialysis supplies noc	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
A4930	Gloves Sterile Per Pair	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
A4931	Reusable oral thermometer	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
A4932	Reusable rectal thermometer	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
A5507	Modification diabetic shoe	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
A6000	Wound warming wound cover	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
A6261	Wound filler gel/paste /oz	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
A6262	Wound filler dry form / gram	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
A6512	Compres burn garment noc	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
A6549	G compression stocking	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
A6550	Neg pres wound ther drsg set	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A7020	Interface For Cough Stimulating Device Includes All Components Replacement Only	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A7025	High Frequency Chest Wall Oscillation System Vest Replacement For Use With Patient Owned Equipment Each	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A7026	High Frequency Chest Wall Oscillation System Hose Replacement For Use With Patient Owned Equipment Each	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A7047	Oral Interface Used With Respiratory Suction Pump Each	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A9150	Misc/exper non-prescript dru	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
A9152	Single vitamin nos	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.	_	_	_
A9153	Multi-vitamin nos	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.	_	_	_
A9180	Pediculosis (Lice Infestation) Treatment Topical For Administration By Patient/Caretaker	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
A9270	Non-covered item or service	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
A9272	Wound Suction Disposable Includes Dressing All Accessories And Components Any Type Each	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A9273	Hot/cold botle/cap/col/wrap	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
A9274	External Ambulatory Insulin Delivery System Disposable Each Includes All Supplies And Accessories	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A9279	Monitoring feature/deviceNOC	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
A9280	Alert device noc	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
A9281	Reaching/Grabbing Device Any Type Any Length Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
A9285	Inversion eversion cor devic	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
A9291	Pres dig cog behav thera fda	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
A9300	Exercise equipment	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
A9515	Choline C-11 Diagnostic Per Study Dose Up To 20 Millicuries	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A9579	Gad-base MR contrast NOS 1ml	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
A9580	Sodium Fluoride F-18 Diagnostic Per Study Dose Up To 30 Millicuries	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A9582	Iodine I-123 Iobenguane Diagnostic Per Study Dose Up To 15 Millicuries	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A9588	Fluciclovine F-18 Diagnostic 1 Millicurie	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A9596	Gallium Illuccix 1 Millicure	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A9597	Pet dx for tumor id noc	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
A9598	Pet dx for non-tumor id noc	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
A9601	Flortaucipir Inj 1 Millicuri	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A9602	Fluorodopa f-18 diag per mci	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A9698	Non-rad contrast materialNOC	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
A9699	Radiopharm rx agent noc	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
A9800	Gallium locametz 1 millicuri	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A9900	Supply/accessory/service	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
A9999	DME supply or accessory nos	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
B4102	EF adult fluids and electro	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
B4103	EF ped fluid and electrolyte	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
B4104	Additive for enteral formula	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_

B4105	Enzyme cartridge enteral nut	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
B4149	EF blenderized foods	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
B4150	EF complet w/intact nutrient	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
B4152	EF calorie dense>/=1.5Kcal	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
B4153	Enteral Formula Nutritionally Complete Hydrolyzed Proteins (Amino Acids And Peptide Chain) Includes Fats Carbohydrates Vitamins And Minerals May Include Fiber Administered Through An Enteral Feeding Tube 100 Calories = 1 Unit	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
B4154	EF spec metabolic noninherit	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
B4155	Enteral Formula Nutritionally Incomplete/Modular Nutrients Includes Specific Nutrients Carbohydrates (E. G. Glucose Polymers) Proteins/Amino Acids (E. G. Glutamine Arginine) Fat (E. G. Medium Chain Triglycerides) Or Combination Administered Through An Enteral Feeding Tube 100 Calories = 1 Unit	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
B4157	Enteral Formula Nutritionally Complete For Special Metabolic Needs For Inherited Disease Of Metabolism Includes Proteins Fats Carbohydrates Vitamins And Minerals May Include Fiber Administered Through An Enteral Feeding Tube 100 Calories = 1 Unit	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
B4158	EF ped complete intact nut	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
B4159	EF ped complete soy based	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
B4160	EF ped caloric dense>/=0.7kc	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
B4161	Enteral Formula For Pediatrics Hydrolyzed/Amino Acids And Peptide Chain Proteins Includes Fats Carbohydrates Vitamins And Minerals May Include Fiber Administered Through An Enteral Feeding Tube 100 Calories = 1 Unit	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
B4162	Enteral Formula For Pediatrics Special Metabolic Needs For Inherited Disease Of Metabolism Includes Proteins Fats Carbohydrates Vitamins And Minerals May Include Fiber Administered Through An Enteral Feeding Tube 100 Calories = 1 Unit	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
B4164	Parenteral 50% dextrose solu	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
B4168	Parenteral Nutrition Solution; Amino Acid 3. 5% (500 Ml = 1 Unit) - Homemix	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
B4172	Parenteral Nutrition Solution; Amino Acid 5. 5% Through 7% (500 Ml = 1 Unit) - Homemix	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
B4176	Parenteral Nutrition Solution; Amino Acid 7% Through 8. 5% (500 Ml = 1 Unit) - Homemix	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
B4178	Parenteral Nutrition Solution: Amino Acid Greater Than 8. 5% (500 Ml = 1 Unit) - Homemix	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
B4180	Parenteral Nutrition Solution; Carbohydrates (Dextrose) Greater Than 50% (500 Ml=1 Unit) - Homemix	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
B4185	Parenteral Nutrition Solution Not Otherwise Specified 10 Grams Lipids	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
B4193	Parenteral Nutrition Solution; Compounded Amino Acid And Carbohydrates With Electrolytes Trace Elements And Vitamins Including Preparation Any Strength 52 To 73 Grams Of Protein - Premix	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
B4197	Parenteral Nutrition Solution; Compounded Amino Acid And Carbohydrates With Electrolytes Trace Elements And Vitamins Including Preparation Any Strength 74 To 100 Grams Of Protein - Premix	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
B4199	Parenteral Nutrition Solution; Compounded Amino Acid And Carbohydrates With Electrolytes Trace Elements And Vitamins Including Preparation Any Strength Over 100 Grams Of Protein - Premix	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
B4216	Parenteral Nutrition; Additives (Vitamins Trace Elements Heparin Electrolytes) Homemix Per Day	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
B4220	Parenteral Nutrition Supply Kit; Premix Per Day	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–

B4222	Parenteral Nutrition Supply Kit; Home Mix Per Day	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
B4224	Parenteral Nutrition Administration Kit Per Day	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
B5000	Parenteral Nutrition Solution Compounded Amino Acid And Carbohydrates With Electrolytes Trace Elements And Vitamins Including Preparation Any Strength Renal-Aminosyn-Rf Nephramine Renamine-Premix	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
B5100	Parenteral Nutrition Solution Compounded Amino Acid And Carbohydrates With Electrolytes Trace Elements And Vitamins Including Preparation Any Strength Hepatic Hepatamine-Premix	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
B5200	Parenteral Nutrition Solution Compounded Amino Acid And Carbohydrates With Electrolytes Trace Elements And Vitamins Including Preparation Any Strength Stress-Branch Chain Amino Acids-Freamine-Hbc-Premix	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
B9004	Parenteral Nutrition Infusion Pump Portable	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
B9006	Parenteral Nutrition Infusion Pump Stationary	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
B9998	Enteral supp not otherwise c	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
B9999	Parenteral supp not othrws c	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
C1052	Hemostatic agent gi topic	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
C1062	Intravertebral body fracture augmentation with implant (e.g., metal, polymer)	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
C1726	Cath Bal Dil Non-Vascular	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
C1761	Cath trans intra litho/coro	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
C1764	Event recorder cardiac	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
C1767	Generator neuro non-recharg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
C1776	Joint device (implantable)	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
C1778	Lead Neurostimulator	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
C1783	Ocular imp aqueous drain de	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
C1787	Patient Progr Neurostim	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
C1816	Receiver/Transmitter Neuro	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
C1817	Septal defect imp sys	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
C1818	Integrated keratoprosthesis	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
C1820	Generator Neurostimulator (Implantable) With Rechargeable Battery And Charging System	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
C1821	Interspinous Process Distraction Device (Implantable)	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
C1823	Gen neuro trans sen/stim	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
C1825	Gen neuro carot sinus baro	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
C1831	Personalized Interbody Cage	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
C1832	Auto cell process sys	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
C1833	Cardiac monitor sys	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
C1883	Adapt/Ext Pacing/Neuro Lead	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
C1889	Implant/insert device noc	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
C2614	Probe Percutaneous Lumbar Discectomy	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
C2616	Brachytx Source Yttrium-90 "Non-Stranded"	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
C2623	Cath translumin drug-coat	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
C2624	Wireless pressure sensor	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
C2698	Brachytx stranded NOS	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
C2699	Brachytx non-stranded NOS	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
C5271	Low cost skin substitute app	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	4/1/2023	–	Add effective 04/01/2023
C5272	Low cost skin substitute app	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	4/1/2023	–	Add effective 04/01/2023
C5273	Low cost skin substitute app	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	4/1/2023	–	Add effective 04/01/2023
C5274	Low cost skin substitute app	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	4/1/2023	–	Add effective 04/01/2023
C5275	Low cost skin substitute app	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	4/1/2023	–	Add effective 04/01/2023
C5276	Low cost skin substitute app	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	4/1/2023	–	Add effective 04/01/2023
C5277	Low cost skin substitute app	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	4/1/2023	–	Add effective 04/01/2023

C5278	Low cost skin substitute app	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	4/1/2023	–	Add effective 04/01/2023
C9257	Bevacizumab injection	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	–	–	–
C9354	Veritas collagen matrix cm2	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
C9356	TenoGlide tendon prot cm2	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
C9358	Dermal substitute native non-denatured collagen fetal bovine origin (SurgiMend Collagen Matrix) per 0.5 square centimeters	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
C9360	SurgiMend neonatal	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
C9363	Integra Meshed Bil Wound Mat	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
C9364	Porcine implant Permacol	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
C9399	unclassified drugs or biologicals	Unlisted Procedure; May require Prior Authorization per contract agreement.	–	–	–
C9734	U/S trtmt not leiomyomata	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
C9739	Cystoscopy prostatic imp 1-3	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
C9740	Cysto impl 4 or more	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
C9757	Spine/lumbar disk surgery	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
C9764	Revasc intravasc lithotripsy	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
C9765	Revasc intra lithotrip-stent	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
C9766	Revasc intra lithotrip-ather	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
C9767	Revasc lithotrip-stent-ather	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
C9768	Endo us-guide hep porto grad	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
C9769	Cysto w/temp pros implant	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
C9770	Vitrec/mech pars subret inj	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
C9771	Nsl/sins cryo post nasal tis	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
C9772	Revasc lithotrip tibi/perone	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
C9773	Revasc lithotr-stent tib/per	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
C9774	Revasc lithotr-ather tib/per	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
C9775	Revasc lith-sten-ath tib/per	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
C9777	Esophag muc integ w/eso egd	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
C9780	Insert cv cath inf & sup app	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
C9898	Inpnt stay radiolabeled item	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
C9899	Inpt implant pros dev no cov	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
D0999	unspecified diagnostic procedure by report	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
D1705	Sarscov2 Covid-19 Vac Rs-Chadox1 5X1010 Vp/.5Ml Im Dose 1	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
D1706	Sarscov2 Covid-19 Vac Rs-Chadox1 5X1010 Vp/.5Ml Im Dose 2	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
D1999	unspecified preventive procedure by report	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
D2999	unspecified restorative procedure by report	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
D3999	unspecified endodontic procedure by report	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
D4999	unspecified periodontal procedure by report	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
D5899	unspecified removable prosthodontic procedure by report	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
D5999	unspecified maxillofacial prosthesis by report	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
D6199	unspecified implant procedure by report	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
D6999	unspecified fixed prosthodontic procedure by report	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
D7999	unspecified oral surgery procedure by report	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
D8999	unspecified orthodontic procedure by report	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
D9999	unspecified adjunctive procedure by report	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
E0181	Powered Pressure Reducing Mattress Overlay/Pad Alternating With Pump Includes Heavy Duty	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0182	Pump For Alternating Pressure Pad For Replacement Only	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0183	Press underlay alter w/pump	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0184	Dry Pressure Mattress	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0185	Gel Or Gel-Like Pressure Pad For Mattress Standard Mattress Length And Width	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0186	Air Pressure Mattress	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–

E0187	Water pressure mattress	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0190	Positioning cushion	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
E0193	Powered Air Flotation Bed (Low Air Loss Therapy)	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0194	Air Fluidized Bed	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0196	Gel Pressure Mattress	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0217	Water circ heat pad w pump	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0218	Fluid circ cold pad w pump	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0221	Infrared heating pad system	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
E0225	Hydrocollator Unit Includes Pads	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0231	Wound warming device	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
E0232	Warming card for NWT	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
E0236	Pump for water circulating p	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0239	Hydrocollator Unit Portable	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0240	Bath/shower chair	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
E0241	Bath tub wall rail	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
E0242	Bath tub rail floor	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
E0243	Toilet rail	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
E0244	Toilet seat raised	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
E0245	Tub stool or bench	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
E0246	Transfer tub rail attachment	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
E0247	Trans bench w/wo comm open	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
E0248	HDtrans bench w/wo comm open	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
E0249	Pad water circulating heat u	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0250	Hospital Bed Fixed Height With Any Type Side Rails With Mattress	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0251	Hospital Bed Fixed Height With Any Type Side Rails Without Mattress	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0255	Hospital Bed Variable Height Hi-Lo With Any Type Side Rails With Mattress	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0256	Hospital Bed Variable Height Hi-Lo With Any Type Side Rails Without Mattress	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0260	Hospital Bed Semi-Electric (Head And Foot Adjustment) With Any Type Side Rails With Mattress	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0261	Hospital Bed Semi-Electric (Head And Foot Adjustment) With Any Type Side Rails Without Mattress	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0265	Hospital Bed Total Electric (Head Foot And Height Adjustments) With Any Type Side Rails With Mattress	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0266	Hospital Bed Total Electric (Head Foot And Height Adjustments) With Any Type Side Rails Without Mattress	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0270	Hospital Bed Institutional Type Includes: Oscillating Circulating And Stryker Frame With Mattress	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0271	Mattress Innerspring	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0272	Mattress Foam Rubber	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0273	Bed board	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0274	Over-bed table	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0277	Powered Pressure-Reducing Air Mattress	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0280	Bed cradle	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0290	Hospital Bed Fixed Height Without Side Rails With Mattress	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0291	Hosp bed fx ht w/o rail w/o	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0292	Hospital Bed Variable Height Hi-Lo Without Side Rails With Mattress	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0293	Hosp bed var ht no sr no mat	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0294	Hospital Bed Semi-Electric (Head And Foot Adjustment) Without Side Rails With Mattress	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0295	Hospital Bed Semi-Electric (Head And Foot Adjustment) Without Side Rails Without Mattress	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0296	Hospital Bed Total Electric (Head Foot And Height Adjustments). Without Side Rails With Mattress	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0297	Hospital Bed Total Electric (Head Foot And Height Adjustments) Without Side Rails Without Mattress	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–

E0300	Pediatric Crib Hospital Grade Fully Enclosed With Or Without Top Enclosure	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0301	Hospital Bed Heavy Duty Extra Wide With Weight Capacity Greater Than 350 Pounds But Less Than Or Equal To 600 Pounds With Any Type Side Rails Without Mattress	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0302	Hospital Bed Extra Heavy Duty Extra Wide With Weight Capacity Greater Than 600 Pounds With Any Type Side Rails Without Mattress	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0303	Hospital Bed Heavy Duty Extra Wide With Weight Capacity Greater Than 350 Pounds But Less Than Or Equal To 600 Pounds With Any Type Side Rails With Mattress	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0304	Hospital Bed Extra Heavy Duty Extra Wide With Weight Capacity Greater Than 600 Pounds With Any Type Side Rails With Mattress	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0305	Bed Side Rails Half Length	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0310	Bed Side Rails Full Length	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0315	Bed accessory brd/tbl/supprt	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0316	Bed safety enclosure	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0328	Hospital Bed Pediatric Manual 360 Degree Side Enclosures Top Of Headboard	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0329	Hospital Bed Pediatric Electric Or Semi-Electric 360 Degree Side Enclosures	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0373	Nonpowered Advanced Pressure Reducing Mattress	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0446	Topical Ox Deliver sys nos	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
E0471	RAD w/backup non inv intrfc	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0481	Intrapulmonary Percussive Ventilation System And Related Accessories	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0482	Cough Stimulating Device Alternating Positive And Negative Airway Pressure	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0483	High Frequency Chest Wall Oscillation System Includes All Accessories And Supplies Each	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0484	Oscillatory Positive Expiratory Pressure Device Non-Electric Any Type Each	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0485	Oral device/appliance prefab	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0486	Oral device/appliance cusfab	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0487	Electronic spirometer	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
E0616	Cardiac event recorder	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0617	Automatic ext defibrillator	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0618	Apnea Monitor Without Recording Feature	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0619	Apnea Monitor With Recording Feature	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0620	Cap bld skin piercing laser	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
E0625	Patient lift bathroom or toi	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
E0627	Seat Lift Mechanism Electric Any Type	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0629	Seat Lift Mechanism Non-Electric Any Type	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0635	Patient Lift Electric With Seat Or Sling	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0636	Multipositional Patient Support System With Integrated Lift Patient Accessible Controls	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0637	Combination Sit To Stand Frame/Table System Any Size Including Pediatric With Seat Lift Feature With Or Without Wheels	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0638	Standing Frame/Table System One Position (E.G. Upright Supine Or Prone Stander) Any Size Including Pediatric With Or Without Wheels	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0639	Patient Lift Moveable From Room To Room With Disassembly And Reassembly Includes All Components/Accessories	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0640	Patient Lift Fixed System Includes All Components/Accessories	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0641	Standing Frame/Table System Multi-Position (E.G. Three-Way Stander) Any Size Including Pediatric With Or Without Wheels	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–

E0642	Standing Frame/Table System Mobile (Dynamic Stander) Any Size Including Pediatric	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0650	Pneuma compresor non-segment	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0651	Pneum compressor segmental	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0652	Pneum compres w/cal pressure	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0655	Pneumatic appliance half arm	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0656	Segmental pneumatic trunk	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0657	Segmental pneumatic chest	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0660	Pneumatic appliance full leg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0665	Pneumatic appliance full arm	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0666	Pneumatic appliance half leg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0667	Seg pneumatic appl full leg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0668	Seg pneumatic appl full arm	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0669	Seg pneumatic appli half leg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0670	Seg pneum int legs/trunk	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0671	Pressure pneum appl full leg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0672	Pressure pneum appl full arm	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0673	Pressure pneum appl half leg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0675	Pneumatic compression device	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
E0676	Inter limb compress dev NOS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0691	Uvl pnl 2 sq ft or less	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0692	Uvl sys panel 4 ft	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0693	Uvl sys panel 6 ft	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0694	Uvl md cabinet sys 6 ft	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0705	Transfer Device Any Type Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
E0720	Transcutaneous Electrical Nerve Stimulation (Tens) Device Two Lead Localized Stimulation	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
E0730	Transcutaneous Electrical Nerve Stimulation (Tens) Device Four Or More Leads For Multiple Nerve Stimulation	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
E0731	Form Fitting Conductive Garment For Delivery Of Tens Or Nmes (With Conductive Fibers Separated From The Patient'S Skin By Layers Of Fabric)	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0740	Non-implant pelv flr e-stim	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
E0744	Neuromuscular Stimulator For Scoliosis	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0746	Electromyograph biofeedback	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0747	Elec osteogen stim not spine	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0760	Osteogen ultrasound stimltor	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0761	Nontherm electromgntc device	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0762	Trans elec jt stim dev sys	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
E0764	Functional neuromuscularstim	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
E0766	Elec stim cancer treatment	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0769	Electric wound treatment dev	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
E0770	Functional electric stim NOS	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
E0781	External ambulatory infus pu	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0782	Infusion Pump Implantable Non-Programmable (Includes All Components E. G. Pump Catheter Connectors Etc.)	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0783	Infusion Pump System Implantable Programmable (Includes All Components E. G. Pump Catheter Connectors Etc.)	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0784	External Ambulatory Infusion Pump Insulin	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0785	Implantable Intraspinal (Epidural/Intrathecal) Catheter Used With Implantable Infusion Pump Replacement	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0786	Implantable Programmable Infusion Pump Replacement (Excludes Implantable Intraspinal Catheter)	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–

E0830	Ambulatory traction device	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
E0840	Tract frame attach headboard	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
E0849	Cervical pneum trac equip	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
E0850	Traction stand free standing	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
E0855	Cervical traction equipment	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
E0856	Cervic collar w air bladders	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
E0860	Tract equip cervical tract	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
E0890	Traction frame attach pelvic	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
E0920	Fracture frame attached to b	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0930	Fracture frame free standing	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0935	Continuous Passive Motion Exercise Device For Use On Knee Only	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0936	CPM device other than knee	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
E0941	Gravity assisted traction de	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0942	Cervical head harness/halter	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
E0944	Pelvic belt/harness/boot	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
E0946	Fracture frame dual w cross	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0947	Fracture Frame Attachments For Complex Pelvic Traction	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0948	Fracture frame attachmnts ce	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0950	Tray	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0953	W/c lateral thigh/knee sup	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0954	Foot box any type each foot	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0955	Cushioned headrest	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0969	Wheelchair narrowing device	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0981	Seat upholstery replacement	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0982	Back upholstery replacement	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0983	Add pwr joystick	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0984	Add pwr tiller	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0985	W/c seat lift mechanism	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0986	Man w/c push-rim powr system	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0988	MANUAL WHEELCHAIR ACCESSORY LEVER-ACTIVATED WHEEL DRIVE PAIR	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0990	Wheelchair elevating leg res	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E0992	Wheelchair solid seat insert	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1002	Pwr seat tilt	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1003	Pwr seat recline	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1004	Pwr seat recline mech	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1005	Pwr seat recline pwr	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1006	Pwr seat combo w/o shear	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1007	Pwr seat combo w/shear	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1008	Pwr seat combo pwr shear	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1009	Add mech leg elevation	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1010	Add pwr leg elevation	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1012	Ctr mount pwr elev leg rest	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1028	W/c manual swingaway	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1031	Rollabout Chair Any And All Types With Castors 5 Or Greater	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1035	Multi-Positional Patient Transfer System With Integrated Seat Operated By Care Giver Patient Weight Capacity Up To And Including 300 Lbs	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1036	Multi-Positional Patient Transfer System Extra-Wide With Integrated Seat Operated By Caregiver Patient Weight Capacity Greater Than 300 Lbs	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–

E1037	Transport Chair Pediatric Size	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1038	Transport Chair Adult Size Patient Weight Capacity Up To And Including 300 Pounds	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1039	Transport Chair Adult Size Heavy Duty Patient Weight Capacity Greater Than 300 Pounds	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1050	Fully-Reclining Wheelchair Fixed Full Length Arms Swing Away Detachable Elevating Leg Rests	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1060	Fully-Reclining Wheelchair Detachable Arms Desk Or Full Length Swing Away Detachable Elevating Legrests	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1070	Fully-Reclining Wheelchair Detachable Arms (Desk Or Full Length) Swing Away Detachable Footrest	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1083	Hemi-wheelchair fixed arms	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1084	Hemi-Wheelchair Detachable Arms Desk Or Full Length Arms Swing Away Detachable Elevating Leg Rests	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1085	Hemi-wheelchair fixed arms	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1086	Hemi-Wheelchair Detachable Arms Desk Or Full Length Swing Away Detachable Footrests	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1087	Wheelchair lightwt fixed arm	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1088	High Strength Lightweight Wheelchair Detachable Arms Desk Or Full Length Swing Away Detachable Elevating Leg Rests	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1089	High Strength Lightweight Wheelchair Fixed Length Arms Swing Away Detachable Footrest	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1090	High Strength Lightweight Wheelchair Detachable Arms Desk Or Full Length Swing Away Detachable Foot Rests	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1092	Wide Heavy Duty Wheel Chair Detachable Arms (Desk Or Full Length) Swing Away Detachable Elevating Leg Rests	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1093	Wide Heavy Duty Wheelchair Detachable Arms Desk Or Full Length Arms Swing Away Detachable Footrests	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1100	Semi-Reclining Wheelchair Fixed Full Length Arms Swing Away Detachable Elevating Leg Rests	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1110	Semi-Reclining Wheelchair Detachable Arms (Desk Or Full Length) Elevating Leg Rest	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1130	Standard Wheelchair Fixed Full Length Arms Fixed Or Swing Away Detachable Footrests	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1140	Wheelchair Detachable Arms Desk Or Full Length Swing Away Detachable Footrests	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1150	Wheelchair Detachable Arms Desk Or Full Length Swing Away Detachable Elevating Legrests	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1160	Wheelchair Fixed Full Length Arms Swing Away Detachable Elevating Legrests	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1161	Manual Adult Size Wheelchair Includes Tilt In Space	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1170	Whlchr ampu fxd arm leg rest	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1171	Wheelchair amputee w/o leg r	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1172	Wheelchair amputee detach ar	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1180	Wheelchair amputee w/ foot r	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1190	Amputee Wheelchair Detachable Arms (Desk Or Full Length) Swing Away Detachable Elevating Legrests	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1195	Wheelchair amputee heavy dut	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1200	Wheelchair amputee fixed arm	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1220	Whlchr special size/constrc	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1221	Wheelchair spec size w foot	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1222	Wheelchair With Fixed Arm Elevating Legrests	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1223	Wheelchair With Detachable Arms Footrests	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1224	Wheelchair With Detachable Arms Elevating Legrests	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1225	Manual semi-reclining back	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1226	Manual fully reclining back	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–

E1227	Wheelchair spec sz spec ht a	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1228	Wheelchair spec sz spec ht b	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1229	Pediatric wheelchair NOS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1230	Power operated vehicle	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1231	Rigid ped w/c tilt-in-space	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1232	Wheelchair Pediatric Size Tilt-In-Space Folding Adjustable With Seating System	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1233	Wheelchair Pediatric Size Tilt-In-Space Rigid Adjustable Without Seating System	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1234	Wheelchair Pediatric Size Tilt-In-Space Folding Adjustable Without Seating System	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1235	Wheelchair Pediatric Size Rigid Adjustable With Seating System	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1236	Wheelchair Pediatric Size Folding Adjustable With Seating System	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1237	Wheelchair Pediatric Size Rigid Adjustable Without Seating System	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1238	Wheelchair Pediatric Size Folding Adjustable Without Seating System	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1239	Ped power wheelchair NOS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1240	Lightweight Wheelchair Detachable Arms (Desk Or Full Length) Swing Away Detachable Elevating Legrest	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1250	Lightweight Wheelchair Fixed Full Length Arms Swing Away Detachable Footrest	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1260	Lightweight Wheelchair Detachable Arms (Desk Or Full Length) Swing Away Detachable Footrest	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1270	Lightweight Wheelchair Fixed Full Length Arms Swing Away Detachable Elevating Legrests	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1280	Heavy Duty Wheelchair Detachable Arms (Desk Or Full Length) Elevating Legrests	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1285	Wheelchair heavy duty fixed	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1290	Heavy Duty Wheelchair Detachable Arms (Desk Or Full Length) Swing Away Detachable Footrest	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1295	Wheelchair heavy duty fixed	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1296	Special Wheelchair Seat Height From Floor	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1297	Special Wheelchair Seat Depth By Upholstery	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1298	Special Wheelchair Seat Depth And/Or Width By Construction	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1300	Whirlpool portable	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
E1310	Whirlpool non-portable	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
E1399	Durable medical equipment mi	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
E1629	Tablo for dialysis service	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1632	Wearable artificial kidney	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
E1699	Dialysis equipment noc	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
E1700	Jaw motion rehab system	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
E1701	Repl cushions for jaw motion	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
E1702	Repl measr scales jaw motion	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
E1800	Dynamic Adjustable Elbow Extension/Flexion Device Includes Soft Interface Material	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1801	Static Progressive Stretch Elbow Device Extension And/Or Flexion With Or Without Range Of Motion Adjustment Includes All Components And Accessories	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1802	Dynamic Adjustable Forearm Pronation/Supination Device Includes Soft Interface Material	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1805	Dynamic Adjustable Wrist Extension / Flexion Device Includes Soft Interface Material	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1806	Static Progressive Stretch Wrist Device Flexion And/Or Extension With Or Without Range Of Motion Adjustment Includes All Components And Accessories	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1810	Dynamic Adjustable Knee Extension / Flexion Device Includes Soft Interface Material	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–

E1811	Static Progressive Stretch Knee Device Extension And/Or Flexion With Or Without Range Of Motion Adjustment Includes All Components And Accessories	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1812	Dynamic Knee Extension/Flexion Device With Active Resistance Control	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1815	Dynamic Adjustable Ankle Extension/Flexion Device Includes Soft Interface Material	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1816	Static Progressive Stretch Ankle Device Flexion And/Or Extension With Or Without Range Of Motion Adjustment Includes All Components And Accessories	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1818	Static Progressive Stretch Forearm Pronation / Supination Device With Or Without Range Of Motion Adjustment Includes All Components And Accessories	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1820	Replacement Soft Interface Material Dynamic Adjustable Extension/Flexion Device	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1821	Replacement Soft Interface Material/Cuffs For Bi-Directional Static Progressive Stretch Device	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1825	Dynamic Adjustable Finger Extension/Flexion Device Includes Soft Interface Material	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1830	Dynamic Adjustable Toe Extension/Flexion Device Includes Soft Interface Material	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1831	Static Progressive Stretch Toe Device Extension And/Or Flexion With Or Without Range Of Motion Adjustment Includes All Components And Accessories	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1840	Dynamic Adjustable Shoulder Flexion / Abduction / Rotation Device Includes Soft Interface Material	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1841	Static Progressive Stretch Shoulder Device With Or Without Range Of Motion Adjustment Includes All Components And Accessories	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E1902	Communication Board Non-Electronic Augmentative Or Alternative Communication Device	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
E2120	Pulse Generator System For Tympanic Treatment Of Inner Ear Endolymphatic Fluid	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2201	Man w/ch acc seat w>=20<24	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2202	Seat width 24-27 in	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2203	Frame depth less than 22 in	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2204	Frame depth 22 to 25 in	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2206	Man wc whl lock comp repl ea	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2207	Crutch and cane holder	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2209	Arm trough each	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2211	Pneumatic propulsion tire	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2212	Pneumatic prop tire tube	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2213	Pneumatic prop tire insert	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2214	Pneumatic caster tire each	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2215	Pneumatic caster tire tube	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2216	Foam filled propulsion tire	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2217	Foam filled caster tire each	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2218	Foam propulsion tire each	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2219	Foam caster tire any size ea	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2220	Solid propuls tire repl ea	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2221	Solid caster tire repl each	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2222	Solid caster integ whl repl	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2228	Mwc acc wheelchair brake	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2230	Manual standing system	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2231	Solid seat support base	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2291	Planar back for ped size wc	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2292	Planar seat for ped size wc	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–

E2293	Contour back for ped size wc	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2294	Contour seat for ped size wc	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2295	Ped dynamic seating frame	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2300	Pwr seat elevation sys	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2301	Pwr standing	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2310	Electro connect btw control	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2311	Electro connect btw 2 sys	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2312	Mini-prop remote joystick	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2313	PWC harness expand control	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2321	Hand interface joystick	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2322	Mult mech switches	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2323	Special joystick handle	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2324	Chin cup interface	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2325	Sip and puff interface	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2326	Breath tube kit	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2327	Head control interface mech	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2328	Head/extremity control inter	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2329	Head control nonproportional	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2330	Head control proximity switc	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2331	Attendant control	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2340	W/c wdth 20-23 in seat frame	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2341	W/c wdth 24-27 in seat frame	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2342	W/c dpth 20-21 in seat frame	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2343	W/c dpth 22-25 in seat frame	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2351	Electronic SGD interface	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2358	POWER WHEELCHAIR ACCESSORY GROUP 34 NON-SEALED LEAD ACID BATTERY EACH	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2359	POWER WHEELCHAIR ACCESSORY GROUP 34 SEALED LEAD ACID BATTERY EACH (E.G. GEL CELL ABSORBED GLASSMAT)	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2360	22nf nonsealed leadacid	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2361	22nf sealed leadacid battery	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2362	Gr24 nonsealed leadacid	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2363	Gr24 sealed leadacid battery	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2364	U1nonsealed leadacid battery	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2365	U1 sealed leadacid battery	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2366	Battery charger single mode	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2367	Battery charger dual mode	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2371	Gr27 sealed leadacid battery	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2372	Gr27 non-sealed leadacid	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2373	Hand/chin ctrl spec joystick	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2374	Hand/chin ctrl std joystick	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2375	Non-expandable controller	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2376	Expandable controller repl	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2377	Expandable controller initl	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2397	Pwc acc lith-based battery	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2402	Neg press wound therapy pump	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2500	SGD digitized pre-rec <=8min	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2502	SGD prerec msg >8min <=20min	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2504	SGD prerec msg>20min <=40min	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2506	SGD prerec msg > 40 min	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2508	SGD spelling phys contact	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–

E2510	SGD w multi methods msg/accs	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2511	SGD sftwre prgrm for PC/PDA	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2512	SGD accessory mounting sys	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2599	SGD accessory noc	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2601	Gen w/c cushion wdth < 22 in	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2602	Gen w/c cushion wdth >=22 in	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2603	Skin protect wc cus wd <22in	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2604	Skin protect wc cus wd>=22in	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2605	Position wc cush wdth <22 in	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2606	Position wc cush wdth>=22 in	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2607	Skin pro/pos wc cus wd <22in	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2608	Skin pro/pos wc cus wd>=22in	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2609	Custom fabricate w/c cushion	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2610	Wheelchair Seat Cushion Powered	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2611	Gen use back cush wdth <22in	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2612	Gen use back cush wdth>=22in	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2613	Position back cush wd <22in	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2614	Position back cush wd>=22in	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2615	Pos back post/lat wdth <22in	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2616	Pos back post/lat wdth>=22in	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2617	Custom fab w/c back cushion	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2620	WC planar back cush wd <22in	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2621	WC planar back cush wd>=22in	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2622	Adj skin pro w/c cus wd<22in	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2623	Adj skin pro wc cus wd>=22in	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2624	Adj skin pro/pos cus<22in	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2625	Adj skin pro/pos wc cus>=22	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2626	WHEELCHAIR ACCESSORY SHOULDER ELBOW MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR BALANCED ADJUSTABLE	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2627	WHEELCHAIR ACCESSORY SHOULDER ELBOW MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR BALANCED ADJUSTABLE RANCHO TYPE	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2628	WHEELCHAIR ACCESSORY SHOULDER ELBOW MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR BALANCED RECLINING	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2629	WHEELCHAIR ACCESSORY SHOULDER ELBOW MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR BALANCED FRICTION ARM SUPPORT (FRICTION DAMPENING TO PROXIMAL AND DISTAL JOINTS)	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2630	WHEELCHAIR ACCESSORY SHOULDER ELBOW MOBILE ARM SUPPORT MONOSUSPENSION ARM AND HAND SUPPORT OVERHEAD ELBOW FOREARM HAND SLING SUPPORT YOKE TYPE SUSPENSION SUPPORT	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2631	WHEELCHAIR ACCESSORY ADDITION TO MOBILE ARM SUPPORT ELEVATING PROXIMAL ARM	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2632	WHEELCHAIR ACCESSORY ADDITION TO MOBILE ARM SUPPORT OFFSET OR LATERAL ROCKER ARM WITH ELASTIC BALANCE CONTROL	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
E2633	WHEELCHAIR ACCESSORY ADDITION TO MOBILE ARM SUPPORT SUPINATOR	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
G0127	Trimming Of Dystrophic Nails Any Number	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
G0151	Services Performed By A Qualified Physical Therapist In The Home Health Or Hospice Setting Each 15 Minutes	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–

G0152	Services Performed By A Qualified Occupational Therapist In The Home Health Or Hospice Setting Each 15 Minutes	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
G0153	Services Performed By A Qualified Speech-Language Pathologist In The Home Health Or Hospice Setting Each 15 Minutes	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
G0157	Services Performed By A Qualified Physical Therapist Assistant In The Home Health Or Hospice Setting Each 15 Minutes	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
G0158	Services Performed By A Qualified Occupational Therapist Assistant In The Home Health Or Hospice Setting Each 15 Minutes	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
G0159	Services Performed By A Qualified Physical Therapist In The Home Health Setting In The Establishment Or Delivery Of A Safe And Effective Physical Therapy Maintenance Program Each 15 Minutes	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
G0160	Services Performed By A Qualified Occupational Therapist In The Home Health Setting In The Establishment Or Delivery Of A Safe And Effective Occupational Therapy Maintenance Program Each 15 Minutes	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
G0161	Services Performed By A Qualified Speech-Language Pathologist In The Home Health Setting In The Establishment Or Delivery Of A Safe And Effective Speech-Language Pathology Maintenance Program Each 15 Minutes	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
G0166	External Counterpulsation Per Treatment Session	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
G0176	OPPS/PHP;activity therapy	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
G0177	Training And Educational Services Related To The Care And Treatment Of Patient'S Disabling Mental Health Problems Per Session (45 Minutes Or More)	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
G0235	Pet imaging any site not otherwise specified	Unlisted Procedure; May require Prior Authorization per contract agreement.	–	–	–
G0255	Current percep threshold tst	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
G0276	Pild/placebo control clin tr	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G0281	Elec stim unattend for press	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
G0282	Elect stim wound care not pd	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
G0283	Electrical Stimulation (Unattended) To One Or More Areas For Indication(S) Other Than Wound Care As Part Of A Therapy Plan Of Care	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G0293	Non-cov surg proc clin trial	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G0294	Non-cov proc clinical trial	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G0295	Electromagnetic therapy onc	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
G0302	Pre-Operative Pulmonary Surgery Services For Preparation For Lvrs Complete Course Of Services To Include A Minimum Of 16 Days Of Services	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
G0303	Pre-Operative Pulmonary Surgery Services For Preparation For Lvrs 10 To 15 Days Of Services	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
G0304	Pre-Operative Pulmonary Surgery Services For Preparation For Lvrs 1 To 9 Days Of Services	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
G0305	Post-Discharge Pulmonary Surgery Services After Lvrs Minimum Of 6 Days Of Services	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
G0310	Immunize counsel 5-15 min	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G0311	Immunize counsel 16-30 mins	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G0312	Immunize couns < 21yr 5-15 m	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G0313	Immunize couns < 21yr 6-30 m	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G0314	Counsel immune <21 16-30 m	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G0315	Counsel immune <21 5-15 m	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G0316	Prolong inpt eval add15 m	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G0317	Prolong nursin fac eval 15m	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G0318	Prolong home eval add 15m	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G0329	Electromagntic tx for ulcers	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
G0330	Facility svs dental rehab	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G0333	Pharmacy Dispensing Fee For Inhalation Drug(S); Initial 30-Day Supply As A Beneficiary	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
G0341	Percutaneous islet celltrans	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–

G0342	Laparoscopy islet cell trans	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
G0343	Laparotomy islet cell transp	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
G0372	Physician Service Required To Establish And Document The Need For A Power Mobility Device (Use In Addition To Primary Evaluation And Management Code)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G0422	Intensive Cardiac Rehabilitation; With Or Without Continuous Ecg Monitoring With Exercise Per Session	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
G0423	Intensive Cardiac Rehabilitation; With Or Without Continuous Ecg Monitoring; Without Exercise Per Session	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
G0428	Collagen Meniscus Implant procedure for filling meniscal defects (e.g. CMI collagen scaffold Menaflex)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
G0429	Dermal Filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g. as a result of highly active antiretroviral therapy.)	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
G0448	Insertion Or Replacement Of A Permanent Pacing Cardioverter-Defibrillator System With Transvenous Lead(S) Single Or Dual Chamber With Insertion Of Pacing Electrode Cardiac Venous System For Left Ventricular Pacing	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
G0455	Fecal microbiota prep instil	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
G0460	Autolog prp not diab ulcer	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
G0465	Autolog prp diab wound ulcer	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
G0516	insert drug del implant >=4	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
G0517	Removal Of Non-Biodegradable Drug Delivery Implants 4 Or More (Services For Subdermal Implants)	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
G0518	Remove w insert drug implant	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
G2011	Alcohol And/Or Substance (Other Than Tobacco) Misuse Structured Assessment (E.G. Audit Dast) And Brief Intervention 5-14 Minutes	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G2082	Visit esketamine 56m or less	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
G2083	Visit esketamine > 56m	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
G3002	Chronic pain mgmt 30 mins	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G3003	Chronic pain mgmt addl 15m	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G8395	LVEF>=40% doc normal or mild	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G8396	LVEF not performed	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G8397	Dil macula/fundus exam/w doc	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G8399	Pt w/dxa results document	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G8400	Pt w/dxa no results doc	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G8404	Low extemity neur exam docum	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G8405	Low extemity neur not perfor	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G8410	Eval on foot documented	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G8415	Eval on foot not performed	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G8416	Pt inelig footwear evaluatio	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G8417	Calc bmi abv up param f/u	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G8418	Calc bmi blw low param f/u	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G8419	Calc bmi out nrm param nof/u	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G8420	Calc bmi norm parameters	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G8421	Bmi not calculated	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G8427	Docrev cur meds by elig clin	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G8428	Cur meds not document	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G8430	Doc med rsn no medrec	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G8431	Pos clin depres scrn f/u doc	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G8432	Dep scr not doc rng	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G8433	Scr for dep not cpt doc rsn	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G8450	Beta-bloc rx pt w/abn lvef	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G8451	Pt w/abn lvef inelig b-bloc	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G8452	Pt w/abn lvef b-bloc no rx	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G8465	High risk recurrence pro ca	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G8473	ACE/ARB thxpy rx?d	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G8474	Ace/arb not rx'd; doc reas	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G8475	ACE/ARB thxpy not rx?d	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G8476	Bp sys <140 and dias <90	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G8477	Bp sys>=140 and/or dias >=90	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G8478	BP not performed/doc	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
G8482	Flu immunize order/admin	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–

G8483	Flu imm no admin doc rea	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G8484	Flu immunize no admin	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9012	Other Specified Case Mgmt	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
G9050	Oncology work-up evaluation	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9051	Oncology tx decision-mgmt	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9052	Onc surveillance for disease	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9053	Onc expectant management pt	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9054	Onc supervision palliative	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9055	Onc visit unspecified NOS	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.	_	_	_
G9056	Onc prac mgmt adheres guide	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9057	Onc pract mgmt differs trial	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9058	Onc prac mgmt disagree w/gui	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9059	Onc prac mgmt pt opt alterna	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9060	Onc prac mgmt dif pt comorb	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9061	Onc prac cond noadd by guide	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9062	Onc prac guide differs nos	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9063	Onc dx nsclc stgI no progres	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9064	Onc dx nsclc stg2 no progres	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9065	Onc dx nsclc stg3A no progre	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9066	Onc dx nsclc stg3B-4 metasta	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9067	Onc dx nsclc dx unknown nos	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9068	Onc dx sclc/nsclc limited	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9069	Onc dx sclc/nsclc ext at dx	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9070	Onc dx sclc/nsclc ext unknwn	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9071	Onc dx brst stg1-2B HR nopro	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9072	Onc dx brst stg1-2 noprogres	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9073	Onc dx brst stg3-HR no pro	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9074	Onc dx brst stg3-noprogress	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9075	Onc dx brst metastic/ recur	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9077	Onc dx prostate T1no progres	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9078	Onc dx prostate T2no progres	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9079	Onc dx prostate T3b-T4noprog	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9080	Onc dx prostate w/rise PSA	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9083	Onc dx prostate unknwn nos	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9084	Onc dx colon t1-3 n1-2 no pr	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9085	Onc dx colon T4 N0 w/o prog	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9086	Onc dx colon T1-4 no dx prog	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9087	Onc dx colon metas evid dx	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9088	Onc dx colon metas noevid dx	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9089	Onc dx colon extent unknown	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9090	Onc dx rectal T1-2 no progr	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9091	Onc dx rectal T3 N0 no prog	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9092	Onc dx rectal T1-3 N1-2noprg	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9093	Onc dx rectal T4 N M0 no prg	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9094	Onc dx rectal M1 w/mets prog	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9095	Onc dx rectal extent unknwn	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9096	Onc dx esophag T1-T3 noprog	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9097	Onc dx esophageal T4 no prog	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9098	Onc dx esophageal mets recur	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9099	Onc dx esophageal unknown	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9100	Onc dx gastric no recurrence	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9101	Onc dx gastric p R1-R2noprog	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9102	Onc dx gastric unresectable	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9103	Onc dx gastric recurrent	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9104	Onc dx gastric unknown NOS	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9105	Onc dx pancreatc p R0 res no	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9106	Onc dx pancreatc p R1/R2 no	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9107	Onc dx pancreatic unresectab	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9108	Onc dx pancreatic unknwn NOS	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9109	Onc dx head/neck T1-T2no prg	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9110	Onc dx head/neck T3-4 noprog	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9111	Onc dx head/neck M1 mets rec	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9112	Onc dx head/neck ext unknown	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9113	Onc dx ovarian stg1A-B no pr	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9114	Onc dx ovarian stg1A-B or 2	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9115	Onc dx ovarian stg3/4 noprog	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9116	Onc dx ovarian recurrence	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9117	Onc dx ovarian unknown NOS	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9123	Onc dx CML chronic phase	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9124	Onc dx CML acceler phase	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9125	Onc dx CML blast phase	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9126	Onc dx CML remission	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_

G9128	Oncology; Disease Status; Limited To Multiple Myeloma Systemic Disease; Smoldering Stage I (For Use In A Medicare-Approved Demonstration Project)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9129	Onc dx mult myeloma stg2 hig	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9130	Onc dx multi myeloma unknown	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9140	Frontier extended stay demo	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G9147	Outpatient Intravenous Insulin Treatment (OIVIT) either pulsatile or continuous by any means guided by the results of measurements for:respiratory quotient; and/or urine urea nitrogen (UUN); and/or arterial venous or capillary glucose; and/or potassium concentration	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
H0031	Mental Health Assessment By Non-Physician	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
H0032	Mental Health Service Plan Development By Non-Physician	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
H0038	Self-Help/Peer Services Per 15 Minutes	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
H0039	Assertive Community Treatment Face-To-Face Per 15 Minutes	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
H0040	Assertive Community Treatment Program Per Diem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
H0041	Foster Care Child Non-Therapeutic Per Diem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
H0042	Foster Care Child Non-Therapeutic Per Month	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
H0043	Supported Housing Per Diem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
H0044	Supported Housing Per Month	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
H0045	Respite Care Services Not In The Home Per Diem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
H0046	Mental health service nos	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
H0047	Alcohol/drug abuse svc nos	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
H1010	Non-Medical Family Planning Education Per Session	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
H1011	Family Assessment By Licensed Behavioral Health Professional For State Defined Purposes	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
H2000	Comprehensive Multidisciplinary Evaluation	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
H2011	Crisis Intervention Service Per 15 Minutes	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
H2012	Behavioral Health Day Treatment Per Hour	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
H2013	Psychiatric Health Facility Service Per Diem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
H2014	Skills Training And Development Per 15 Minutes	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
H2015	Comprehensive Community Support Services Per 15 Minutes	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
H2016	Comprehensive Community Support Services Per Diem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
H2021	Community-Based Wrap-Around Services Per 15 Minutes	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
H2022	Community-Based Wrap-Around Services Per Diem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
H2023	Supported Employment Per 15 Minutes	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
H2024	Supported Employment Per Diem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
H2025	Ongoing Support To Maintain Employment Per 15 Minutes	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
H2026	Ongoing Support To Maintain Employment Per Diem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
H2027	Psychoeducational Service Per 15 Minutes	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
H2028	Sexual Offender Treatment Service Per 15 Minutes	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
H2029	Sexual Offender Treatment Service Per Diem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
H2030	Mental Health Clubhouse Services Per 15 Minutes	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
H2031	Mental Health Clubhouse Services Per Diem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
H2032	Activity Therapy Per 15 Minutes	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
H2033	Multisystemic Therapy For Juveniles Per 15 Minutes	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
H2034	Alcohol And/Or Drug Abuse Halfway House Services Per Diem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
H2037	Developmental Delay Prevention Activities Dependent Child Of Client Per 15 Minutes	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
J0129	Abatacept injection	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J0172	Inj aducanumab-avwa 2 mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J0178	Injection Aflibercept 1 Mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J0180	Agalsidase beta injection	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_

J0202	Injection alemtuzumab	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J0215	Injection Alefacept 0. 5 Mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J0219	Inj aval alfa-nqpt 4mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J0220	Alglucosidase alfa injection	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J0221	INJECTION ALGLUCOSIDASE ALFA (LUMIZYME) 10 MG	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J0222	Inj. patisiran 0.1 mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J0223	Inj givosiran 0.5 mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J0224	Inj. lumasiran 0.5 mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J0225	Inj vutrisiran 1 mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	1/1/2023	_	Add effective 01/01/2023
J0256	Alpha 1 proteinase inhibitor	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
J0270	Alprostadil for injection	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J0275	Alprostadil urethral suppos	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J0470	Injection Dimercaprol Per 100 Mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J0490	INJECTION BELIMUMAB 10 MG	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J0491	Inj anifrolumab-fnia 1mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J0517	Inj. benralizumab 1 mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J0565	Inj bezlotoxumab 10 mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J0567	Inj. cerliponase alfa 1 mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J0584	Injection burosumab-twza 1m	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J0585	Injection onabotulinumtoxinA	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J0586	AbobotulinumtoxinA	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J0587	Inj rimabotulinumtoxinB	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J0588	INJECTION INCOBOTULINUMTOXIN A 1 UNIT	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J0598	C-1 esterase cinryze	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J0600	Edetate calcium disodium inj	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J0638	Canakinumab injection	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J0717	Certolizumab pegol inj 1mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J0775	Collagenase clost hist inj	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J0791	Inj crizanlizumab-tmca 5mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J0881	Darbepoetin alfa non-esrd	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J0888	Epoetin beta non esrd	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J0895	Injection Deferoxamine Mesylate 500 Mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J1071	Injection Testosterone Cypionate 1Mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J1290	Ecallantide injection	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J1300	Eculizumab injection	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J1301	Injection edaravone 1 mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J1302	Inj sutimlimab-jome 10 mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

J1303	Inj. ravulizumab-cwvz 10 mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J1305	Inj evinacumab-dgnb 5mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J1306	Injection inclisiran 1 mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J1322	Elosulfase alfa injection	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J1325	Epoprostenol injection	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J1426	Injection casimersen 10 mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J1427	Inj. viltolarsen	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J1428	Inj eteplirsen 10 mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J1429	Inj golodirsen 10 mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J1458	Galsulfase injection	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J1551	Inj cutaquig 100 mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J1554	Inj. asceniv	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J1562	Vivaglobin inj	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J1566	Immune globulin powder	Unlisted Procedure; May require Prior Authorization per contract agreement.	_	_	_
J1599	Ivig non-lyophilized NOS	Unlisted Procedure; May require Prior Authorization per contract agreement.	_	_	_
J1602	Golimumab for iv use 1mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J1620	Injection Gonadorelin Hydrochloride Per 100 Mcg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J1632	Inj. brexanolone 1 mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J1675	Histrelin acetate	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J1726	Makena 10 mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J1729	Inj hydroxyprogst capoat nos	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J1743	Idursulfase injection	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J1745	Infliximab not biosimil 10mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J1746	Inj. ibalizumab-uiyk 10 mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J1786	Imuglucerase injection	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J1823	Inj. inebilizumab-cdon 1 mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J1931	Laronidase injection	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J1932	Inj lanreotide (cipla) 1mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J1951	Inj fensolvi 0.25 mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J1954	Inj lutrate depot 7.5 mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J2182	Injection mepolizumab 1mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J2278	Ziconotide injection	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J2320	Injection Nandrolone Decanoate Up To 50 Mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J2323	Natalizumab injection	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J2326	Inj nusinersen 0.1mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J2350	Injection ocrelizumab 1 mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J2356	Inj tezepelumab-ekko 1mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J2357	Omalizumab injection	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_

J2440	Injection Papaverine Hcl Up To 60 Mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
J2502	Inj pasireotide long acting	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	–	–	–
J2503	Pegaptanib sodium injection	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
J2507	INJECTION PEGLOTICASE 1 MG	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	–	–	–
J2777	Inj faricimab-svoa 0.1mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
J2778	Injection Ranibizumab 0.1 Mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
J2779	Inj susvimo 0.1 mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
J2786	Injection reslizumab 1mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	–	–	–
J2787	Riboflavin 5'Phos opth<=3ml	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
J2840	Inj sebelipase alfa 1 mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	–	–	–
J3032	Inj. eptinezumab-jjmr 1 mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	–	–	–
J3060	Inj taliglucerace alfa 10 u	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	–	–	–
J3121	Inj testostero enanthate 1mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	–	–	–
J3145	Testosterone undecanoate 1mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	–	–	–
J3241	Inj. teprotumumab-trbw 10 mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	–	–	–
J3245	Inj. tildrakizumab 1 mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	–	–	–
J3262	Tocilizumab injection	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	–	–	–
J3285	Treprostinil injection	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	–	–	–
J3299	Inj xipere 1 mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
J3316	Inj. triptorelin xr 3.75 mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
J3355	Injection Urofollitropin 75 Iu	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
J3358	Ustekinumab iv inject 1 mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	–	–	–
J3380	Injection vedolizumab	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	–	–	–
J3385	Velaglucerase alfa	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	–	–	–
J3396	Verteporfin injection	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
J3397	Inj. vestronidase alfa-vjbk	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	–	–	–
J3398	Inj luxturna 1 billion vec g	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	–	–	–
J3399	Inj onase abepar-xioi treat	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	–	–	–
J3490	Drugs unclassified injection	Unlisted Procedure; May require Prior Authorization per contract agreement.	–	–	–
J3520	Edetate disodium per 150 mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
J3570	Laetrile amygdalin vit B17	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
J3590	Unclassified biologics	Unlisted Procedure; May require Prior Authorization per contract agreement.	–	–	–
J3591	Esrd on dialysi drug/bio noc	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
J7177	Inj. fibryga 1 mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
J7178	Inj human fibrinogen con nos	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	–	–	–
J7192	Factor viii recombinant NOS	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
J7195	Factor ix recombinant nos	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
J7199	Hemophilia clot factor noc	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
J7308	Aminolevulinic Acid Hcl For Topical Administration 20% Single Unit Dosage Form (354 Mg)	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
J7309	Methyl Aminolevulinate (Mal) For Topical Administration 16.8% 1 Gram	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
J7311	Inj. retisert 0.01 mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
J7312	Injection Dexamethasone Intravitreal Implant 0.1 Mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–

J7313	Inj. iluvien 0.01 mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J7316	Injection Ocriplasmin 0.125 Mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J7340	Carbidopa levodopa ent 100ml	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J7345	Aminolevulinic Acid Hcl For Topical Administration 10% Gel 10 Mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J7351	Inj bimatoprost itc imp1mcg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J7402	Mometasone sinus sinuva	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J7599	Immunosuppressive drug noc	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
J7604	Acetylcysteine comp unit	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
J7607	Levalbuterol comp con	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
J7609	Albuterol comp unit	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
J7610	Albuterol comp con	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
J7615	Levalbuterol comp unit	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
J7622	Beclomethasone comp unit	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
J7624	Betamethasone comp unit	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
J7627	Budesonide comp unit	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
J7628	Bitolterol mesylate comp con	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
J7629	Bitolterol mesylate comp unt	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
J7632	Cromolyn sodium comp unit	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
J7634	Budesonide comp con	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
J7635	Atropine comp con	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
J7636	Atropine comp unit	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
J7637	Dexamethasone comp con	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
J7638	Dexamethasone comp unit	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
J7640	Formoterol comp unit	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
J7641	Flunisolide comp unit	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
J7642	Glycopyrrolate comp con	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
J7643	Glycopyrrolate comp unit	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
J7645	Ipratropium bromide comp	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
J7647	Isoetharine comp con	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
J7650	Isoetharine comp unit	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
J7657	Isoproterenol comp con	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
J7660	Isoproterenol comp unit	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
J7667	Metaproterenol comp con	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
J7670	Metaproterenol comp unit	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
J7676	Pentamidine comp unit dose	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
J7680	Terbutaline sulf comp con	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
J7681	Terbutaline sulf comp unit	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
J7683	Triamcinolone comp con	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
J7684	Triamcinolone comp unit	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
J7685	Tobramycin comp unit	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
J7699	Inhalation solution for DME	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
J7799	Non-inhalation drug for DME	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
J7999	Compounded drug noc	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
J8498	Antiemetic rectal/supp NOS	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
J8499	Oral prescrip drug non chemo	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
J8597	Antiemetic drug oral NOS	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
J8999	Oral prescription drug chemo	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
J9020	Asparaginase NOS	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
J9247	Inj melphalan flufenami 1mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J9274	Inj tebentafusp-tebn 1 mcg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J9285	Inj olaratumab 10 mg	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
J9331	Inj sirolimus prot part 1 mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_

J9332	Inj efgartigimod 2mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	–	–	–
J9600	Porfimer sodium injection	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
J9999	Chemotherapy drug	Unlisted Procedure; May require Prior Authorization per contract agreement.	–	–	–
K0002	Stnd hemi (low seat) whlchr	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0003	Lightweight wheelchair	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0004	High strength ltwt whlchr	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0005	Ultralightweight wheelchair	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0006	Heavy duty wheelchair	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0007	Extra heavy duty wheelchair	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0008	Cstm manual wheelchair/base	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0009	Other manual wheelchair/base	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0010	Stnd wt frame power whlchr	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0011	Stnd wt pwr whlchr w control	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0012	Ltwt portbl power whlchr	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0013	Custom power whlchr base	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0014	Other power whlchr base	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0053	Elevate footrest articulate	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0056	Seat ht <17 or >=21 ltwt wc	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0065	Spoke protectors	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0108	W/c component-accessory NOS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0455	Pump uninterrupted infusion	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0669	Seat/back cus no dmepdac ver	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0743	SUCTION PUMP HOME MODEL PORTABLE FOR USE ON WOUNDS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0744	ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP HOME MODEL PORTABLE PAD SIZE 16 SQUARE INCHES OR LESS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0745	Absorptive Wound Dressing For Use With Suction Pump, Home Model, Portable, Pad Size More Than 16 Square Inches But Less Than Or Equal To 48 Square Inches	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0746	ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP HOME MODEL PORTABLE PAD SIZE GREATER THAN 48 SQUARE INCHES	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0800	POV group 1 std up to 300lbs	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0801	POV group 1 hd 301-450 lbs	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0802	POV group 1 vhd 451-600 lbs	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0806	POV group 2 std up to 300lbs	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0807	POV group 2 hd 301-450 lbs	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0808	POV group 2 vhd 451-600 lbs	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0812	Power operated vehicle NOC	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0813	PWC gp 1 std port seat/back	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0814	PWC gp 1 std port cap chair	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0815	PWC gp 1 std seat/back	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0816	PWC gp 1 std cap chair	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0820	PWC gp 2 std port seat/back	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0821	PWC gp 2 std port cap chair	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0822	PWC gp 2 std seat/back	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0823	PWC gp 2 std cap chair	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0824	PWC gp 2 hd seat/back	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0825	PWC gp 2 hd cap chair	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0826	PWC gp 2 vhd seat/back	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0827	PWC gp vhd cap chair	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0828	PWC gp 2 xtra hd seat/back	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–

K0829	PWC gp 2 xtra hd cap chair	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0830	PWC gp2 std seat elevate s/b	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0831	PWC gp2 std seat elevate cap	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0835	PWC gp2 std sing pow opt s/b	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0836	PWC gp2 std sing pow opt cap	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0837	PWC gp 2 hd sing pow opt s/b	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0838	PWC gp 2 hd sing pow opt cap	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0839	PWC gp2 vhd sing pow opt s/b	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0840	PWC gp2 xhd sing pow opt s/b	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0841	PWC gp2 std mult pow opt s/b	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0842	PWC gp2 std mult pow opt cap	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0843	PWC gp2 hd mult pow opt s/b	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0848	PWC gp 3 std seat/back	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0849	PWC gp 3 std cap chair	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0850	PWC gp 3 hd seat/back	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0851	PWC gp 3 hd cap chair	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0852	PWC gp 3 vhd seat/back	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0853	PWC gp 3 vhd cap chair	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0854	PWC gp 3 xhd seat/back	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0855	PWC gp 3 xhd cap chair	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0856	PWC gp3 std sing pow opt s/b	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0857	PWC gp3 std sing pow opt cap	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0858	PWC gp3 hd sing pow opt s/b	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0859	PWC gp3 hd sing pow opt cap	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0860	PWC gp3 vhd sing pow opt s/b	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0861	PWC gp3 std mult pow opt s/b	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0862	PWC gp3 hd mult pow opt s/b	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0863	PWC gp3 vhd mult pow opt s/b	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0864	PWC gp3 xhd mult pow opt s/b	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0868	PWC gp 4 std seat/back	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0869	PWC gp 4 std cap chair	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0870	PWC gp 4 hd seat/back	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0871	PWC gp 4 vhd seat/back	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0877	PWC gp4 std sing pow opt s/b	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0878	PWC gp4 std sing pow opt cap	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0879	PWC gp4 hd sing pow opt s/b	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0880	PWC gp4 vhd sing pow opt s/b	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0884	PWC gp4 std mult pow opt s/b	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0885	PWC gp4 std mult pow opt cap	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0886	PWC gp4 hd mult pow s/b	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0890	PWC gp5 ped sing pow opt s/b	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0891	PWC gp5 ped mult pow opt s/b	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K0898	Power wheelchair NOC	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
K0899	Pow mobil dev no dmepdac	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
K1002	Ces system	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
K1004	Lo freq us diathermy device	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
K1007	Bil hkaf pc s/d micro sensor	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
K1009	Speech volume modulation sys	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
K1013	Enema tube, any, replac only	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
K1018	Ext up limb tremor stim wris	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
K1019	Supp ext up limb tremor stim	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–

K1020	Non-invasive vagus nerv stim	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K1021	Exsuff belt incl all sup acc	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K1022	Endoskel posit rotat unit	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K1023	Trans elec nerv periph nerv	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
K1024	Non pneum comp control cal	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
K1025	Non pneum compress full arm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
K1027	Oral dev without fix mech	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K1028	Control Unit Neuromuscul Osa	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K1029	Oral Dv/App Neuromus Mouthpi	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K1030	Ext recharge bat replacement	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K1031	Non pneu comp control w/o ca	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
K1031	Non pneu comp control w/o ca	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
K1032	Non pneum seq comp full leg	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
K1032	Non pneum seq comp full leg	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
K1033	Non pneum seq comp half leg	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
K1033	Non pneum seq comp half leg	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
L0120	Cerv flex n/adj foam pre ots	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L0999	Add to spinal orthosis NOS	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
L1499	Spinal orthosis NOS	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
L1834	Ko w/0 joint rigid molded to	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L1840	Ko derot ant cruciate custom	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L1844	Ko w/adj jt rot cntrl molded	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L1846	Ko w adj flex/ext rotat mold	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L1860	Ko supracondylar socket mold	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L2005	KAFO sng/dbl mechanical act	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L2999	Lower extremity orthosis NOS	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
L3001	Foot insert remov molded spe	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3002	Foot insert plastazote or eq	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3003	Foot insert silicone gel eac	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3010	Foot longitudinal arch suppo	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3020	Foot longitud/metatarsal sup	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3030	Foot arch support remov prem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3031	Foot lamin/prepreg composite	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3040	Ft arch suprt premold longit	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3050	Foot arch supp premold metat	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3060	Foot arch supp longitud/meta	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3070	Arch suprt att to sho longit	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3080	Arch supp att to shoe metata	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3090	Arch supp att to shoe long/m	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3100	Hallus-valgus nt dyn pre ots	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3140	Abduction rotation bar shoe	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3150	Abduct rotation bar w/o shoe	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3160	Shoe styled positioning dev	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3170	Foot plas heel stabi pre ots	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3201	Oxford w supinat/pronat inf	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3202	Oxford w/ supinat/pronator c	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3203	Oxford w/ supinator/pronator	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3204	Hightop w/ supp/pronator inf	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3206	Hightop w/ supp/pronator chi	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3207	Hightop w/ supp/pronator jun	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3212	Benesch boot pair infant	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3213	Benesch boot pair child	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3214	Benesch boot pair junior	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3215	Orthopedic ftwear ladies oxf	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3216	Orthoped ladies shoes dpth i	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3217	Ladies shoes hightop depth i	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3219	Orthopedic mens shoes oxford	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3221	Orthopedic mens shoes dpth i	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3222	Mens shoes hightop depth inl	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3224	Woman's shoe oxford brace	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3225	Man's shoe oxford brace	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3230	Custom shoes depth inlay	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3250	Custom mold shoe remov prost	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_

L3251	Shoe molded to pt silicone s	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3252	Shoe molded plastazote cust	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3253	Shoe molded plastazote cust	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3254	Orth foot non-stndard size/w	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3255	Orth foot non-standard size/	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3257	Orth foot add charge split s	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3265	Plastazote sandal each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3300	Sho lift taper to metatarsal	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3310	Shoe lift elev heel/sole neo	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3320	Shoe lift elev heel/sole cor	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3330	Lifts elevation metal extens	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3332	Shoe lifts tapered to one-ha	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3334	Shoe lifts elevation heel /i	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3340	Shoe wedge sach	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3350	Shoe heel wedge	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3360	Shoe sole wedge outside sole	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3370	Shoe sole wedge between sole	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3380	Shoe clubfoot wedge	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3390	Shoe outflare wedge	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3400	Shoe metatarsal bar wedge ro	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3410	Shoe metatarsal bar between	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3420	Full sole/heel wedge btween	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3430	Sho heel count plast reinfor	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3440	Heel leather reinforced	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3450	Shoe heel sach cushion type	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3455	Shoe heel new leather standa	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3460	Shoe heel new rubber standar	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3465	Shoe heel thomas with wedge	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3470	Shoe heel thomas extend to b	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3480	Shoe heel pad & depress for	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3485	Shoe heel pad removable for	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3500	Ortho shoe add leather insol	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3510	Orthopedic shoe add rub insl	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3520	O shoe add felt w leath insl	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3530	Ortho shoe add half sole	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3540	Ortho shoe add full sole	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3550	O shoe add standard toe tap	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3560	O shoe add horseshoe toe tap	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3570	O shoe add instep extension	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3580	O shoe add instep velcro clo	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3590	O shoe convert to sof counte	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3595	Ortho shoe add march bar	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3600	Trans shoe calip plate exist	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3610	Trans shoe caliper plate new	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3620	Trans shoe solid stirrup exi	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3630	Trans shoe solid stirrup new	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3640	Shoe dennis browne splint bo	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3649	Orthopedic shoe modifica NOS	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.	_	_	_
L3999	Upper limb orthosis NOS	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
L5610	Above knee hydracadence	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5611	Ak 4 bar link w/fric swing	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5613	Ak 4 bar ling w/hydraul swig	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5614	4-bar link above knee w/swng	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5616	Ak univ multiplex sys frict	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5620	Test socket below knee	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5624	Test socket above knee	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5629	Below knee acrylic socket	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5631	Ak/knee disartic acrylic soc	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5638	Below knee leather socket	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5639	Below knee wood socket	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5640	Knee disarticulat leather so	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5642	Above knee leather socket	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5644	Above knee wood socket	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5645	Bk flex inner socket ext fra	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5646	Below knee cushion socket	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

L5647	Below knee suction socket	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5648	Above knee cushion socket	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5651	Ak flex inner socket ext fra	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5652	Suction susp ak/knee disart	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5670	Bk molded supracondylar susp	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5676	Bk knee joints single axis p	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5704	Custom shape cover BK	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5705	Custom shape cover AK	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5706	Custom shape cvr knee disart	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5710	Kne-shin exo sng axi mnl loc	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5711	Knee-shin exo mnl lock ultra	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5712	Knee-shin exo frict swg & st	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5714	Knee-shin exo variable frict	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5716	Knee-shin exo mech stance ph	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5718	Knee-shin exo frct swg & sta	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5722	Knee-shin pneum swg frct exo	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5724	Knee-shin exo fluid swing ph	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5726	Knee-shin ext jnts fld swg e	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5728	Knee-shin fluid swg & stance	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5780	Knee-shin pneum/hydra pneum	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5785	Exoskeletal bk ultralt mater	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5790	Exoskeletal ak ultra-light m	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5795	Exoskel hip ultra-light mate	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5810	Endoskel knee-shin mnl lock	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5811	Endo knee-shin mnl lck ultra	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5812	Endo knee-shin frct swg & st	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5814	Endo knee-shin hydral swg ph	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5816	Endo knee-shin polyc mch sta	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5818	Endo knee-shin frct swg & st	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5822	Endo knee-shin pneum swg frc	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5824	Endo knee-shin fluid swing p	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5826	Miniature knee joint	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5828	Endo knee-shin fluid swg/sta	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5830	Endo knee-shin pneum/swg pha	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5840	Multi-axial knee/shin system	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5848	Knee-shin sys hydraul stance	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5856	Elec knee-shin swing/stance	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5857	Elec knee-shin swing only	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5858	Stance phase only	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5859	Knee-shin pro flex/ext cont	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5961	Endo poly hip pneu/hyd/rot	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5962	Below knee flex cover system	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5964	Above knee flex cover system	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5966	Hip flexible cover system	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5968	Multiaxial ankle w dorsiflex	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5969	Ak/ft power asst incl motors	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5970	Foot external keel sach foot	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5972	Flexible keel foot	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5973	Ank-foot sys dors-plant flex	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5974	Foot single axis ankle/foot	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–

L5976	Energy storing foot	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5978	Ft prosth multiaxial ankl/ft	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5979	Multi-axial ankle/ft prosth	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5980	Flex foot system	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5981	Flex-walk sys low ext prosth	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5982	Exoskeletal axial rotation u	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5984	Endoskeletal axial rotation	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5985	Lwr ext dynamic prosth pylon	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5986	Multi-axial rotation unit	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5987	Shank ft w vert load pylon	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L5999	Lowr extremity prosthes NOS	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
L6026	Part hand myo exclu term dev	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L6611	Additional switch ext power	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L6621	Flex/ext wrist w/wo friction	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L6715	Terminal Device Multiple Articulating Digit Includes Motor(S) Initial Issue Or Replacement	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L6880	ELECTRIC HAND SWITCH OR MYOLELECTRIC CONTROLLED INDEPENDENTLY ARTICULATING DIGITS ANY GRASP PATTERN OR COMBINATION OF GRASP PATTERNS INCLUDES MOTOR(S)	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L6882	Microprocessor control uplmb	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L6920	Wrist disarticul switch ctrl	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L6925	Wrist disart myoelectronic c	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L6930	Below elbow switch control	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L6935	Below elbow myoelectronic ct	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L6940	Elbow disarticulation switch	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L6945	Elbow disart myoelectronic c	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L6950	Above elbow switch control	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L6955	Above elbow myoelectronic ct	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L6960	Shldr disartic switch contro	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L6965	Shldr disartic myoelectronic	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L6970	Interscapular-thor switch ct	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L6975	Interscap-thor myoelectronic	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L7007	Adult electric hand	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L7008	Pediatric electric hand	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L7009	Adult electric hook	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L7040	Prehensile actuator	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L7045	Pediatric electric hook	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L7170	Electronic elbow hosmer swit	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L7180	Electronic elbow sequential	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L7181	Electronic elbo simultaneous	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L7185	Electron elbow adolescent sw	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L7186	Electron elbow child switch	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L7190	Elbow adolescent myoelectron	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L7191	Elbow child myoelectronic ct	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L7259	Electronic wrist rotator any	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L7360	Six volt bat otto bock/eq ea	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L7362	Battery chrgr six volt otto	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L7364	Twelve volt battery utah/equ	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L7366	Battery chrgr 12 volt utah/e	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L7367	Replacemnt lithium ionbatter	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
L7368	Lithium ion battery charger	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–

L7499	Upper extremity prosthes NOS	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
L7900	Male vacuum erection system	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L7902	Tension Ring Vac Erect Dev	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L8039	Breast prosthesis NOS	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
L8048	Unspec maxillofacial prosth	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
L8499	Unlisted misc prosthetic ser	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
L8604	Dextranomer/hyaluronic acid	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L8605	Inj bulking agent anal canal	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
L8606	Synthetic implnt urinary 1ml	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L8607	Inj vocal cord bulking agent	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L8608	Arg ii ext com/sup/acc misc	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
L8609	Artificial cornea	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L8612	Aqueous shunt prosthesis	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L8679	Imp neurosti pls gn any type	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L8680	Implt neurostim elctr each	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L8681	Pt prgrm for implt neurostim	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L8682	Implt neurostim radiofq rec	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L8689	External recharg sys intern	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L8694	Aoi transducer/actuator repl	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L8695	External recharg sys extern	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L8698	Misc used with tot art heart	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L8699	Prosthetic implant NOS	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
L8701	Ewh s/d uprt micro sensor	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L8702	Ewhf s/d uprt micro sensor	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
M0001	Advancing cancer care mvp	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M0002	Opt care kidney hlth mvp	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M0003	Opt care episod neuro mvp	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M0004	Support care neur cond mvp	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M0005	Promot wellness mvp	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M0075	Cellular therapy	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M0076	Prolotherapy	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
M0100	Intragastric hypothermia	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M0300	IV chelationtherapy	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
M1150	Lvef <=40% or mod/sev l vsf	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1151	Pt w/ hx trnsplt or lvad	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1152	Pt w/ hx trnsplt or lvad	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1153	Pt w/ dx osteo doe	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1154	Hospc serv dur meas pd	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1155	Pt anphx due to pneum	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1156	Pt recd actv chemo any time	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1157	Pt recd bone mar trnsplt	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1158	Pt hx immcomp prior/dur pd	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1159	Hospc serv dur meas pd	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1160	Pt anphx due to mengb bef 13	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1161	Pt anphx due to dtp bef 13	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1162	Pt enceph due to dtp bef 13	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1163	Pt anphx due to hpv bef 13	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1164	Pt w/ dementia any time	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1165	Pt use hspc dur meas pd	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1166	Path rpt tis spec wle/reexc	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1167	Hspc dur meas pd	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1168	Pt recd flu vax 7/1-6/30	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1169	Doc med rsn no flu vax	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1170	Pt w/o flu vax 7/1-6/30	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1171	Pt recd 1 td/tdap 9yrs prior	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1172	Doc med rsn no td/tdap	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1173	Pt no rec td/tdap 9yrs prior	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1174	Pt w/ 1 hzv lv or 2 hzv recm	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1175	Doc med rsn no hzv	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1176	Pt w/o hzv on/aft age 50	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1177	Pt recd pcv on/aft 60	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1178	Doc med rsn no pcv	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1179	No pcv recd	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_

M1180	Pt imm ckpt inhib therapy	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1181	Gr 2 or> dia or gr2 or> col	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1182	Not elg pre ex ibd/uc/crohn	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1183	Doc imm ckpt inhib hld	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1184	Doc med rsn no cst/ist rx	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1185	Imm ckpt inhib not hld no rx	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1186	Pt w/ rx for hspc/plltv care	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1187	Pt w/ esrd	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1188	Pt w/ ckd stg 5	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1189	Doc khe pef w/efgr/uacr	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1190	Doc khe not pef w/efgr/uacr	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1191	Hspc svc any time in meas pd	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1192	Pt w/ dx sq cell ca of esoph	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1193	Rpts w/ imp/con mmr/msi	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1194	Med rsn no imp/con mmr/msi	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1195	Rpt wo imp/con mmr/msi	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1196	Ixv nrs vrs iqa >=4	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1197	Isa red >=2 fr ixv	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1198	Isa not red 2pts fr ixv	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1199	Pt rec'g rrt	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1200	Ace-i/arb rx	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1201	Med rsn no ace-i/arb rx	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1202	Pt rsn no ace-i/arb rx	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1203	No rsn ace-i/arb rx	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1204	Ixv nrs vrs iqa >=4	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1205	Isa red >=2 fr ixv	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1206	Isa not red 2pts fr ixv	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1207	#pts scrn sdoh	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1208	#pts no scrn sdoh	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1209	>=2 same hi-rsk med w/o diag	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1210	>=2 same meds tbl4 not ord	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
P2031	Hair analysis	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
P9020	Plaelet rich plasma unit	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
P9099	Blood component/product noc	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
Q0035	Cardiokymography	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
Q0114	Fern test	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
Q0115	Post-coital mucous exam	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
Q0243	casirivimab and imdevimab	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
Q0244	Casirivi and imdevi 1200 mg	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
Q0245	bamlanivimab and etesevima	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
Q0477	Pwr module pt cable lvad rpl	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0478	Power adapter combo vad	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0479	Power module combo vad rep	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0480	Driver pneumatic vad rep	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0481	Microprcsr cu elec vad rep	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0482	Microprcsr cu combo vad rep	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0483	Monitor elec vad rep	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0484	Monitor elec or comb vad rep	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0485	Monitor cable elec vad rep	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0486	Mon cable elec/pneum vad rep	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0487	Leads any type vad rep only	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0488	Pwr pack base elec vad rep	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0489	Pwr pck base combo vad rep	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0490	Emr pwr source elec vad rep	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0491	Emr pwr source combo vad rep	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0492	Emr pwr cbl elec vad rep	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0493	Emr pwr cbl combo vad rep	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0494	Emr hd pmp elec/combo rep	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0495	Charger elec/combo vad rep	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0496	Battery elec/combo vad rep	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0497	Bat clps elec/comb vad rep	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0498	Holster elec/combo vad rep	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

Q0499	Belt/vest elec/combo vad rep	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
Q0500	Filters elec/combo vad rep	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
Q0501	Shwr cov elec/combo vad rep	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
Q0502	Mobility cart pneum vad rep	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
Q0503	Battery pneum vad replacemnt	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
Q0504	Pwr adpt pneum vad rep veh	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
Q0506	Lith-ion batt elec/pneum VAD	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
Q0507	Misc sup/acc ext VAD	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
Q0508	Misc sup/acc imp VAD	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
Q0509	Mis sup/ac imp VAD nopay med	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
Q2026	Radiesse injection	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
Q2028	Inj sculptra 0.5mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
Q2039	Influenza virus vaccine nos	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
Q2041	Axicabtagene ciloleucel car+	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	–	–	–
Q2050	Doxorubicin inj 10mg	Unlisted Procedure; May require Prior Authorization per contract agreement.	–	–	–
Q2052	Ivig demo services/supplies	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
Q2053	Brexucabtagene car pos t	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	–	–	–
Q2054	Lisocabtagene mara car pos t	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	–	–	–
Q2055	Idecabtagene vicleucel car	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	–	–	–
Q2056	Ciltacabtagene car-pos t	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	–	–	–
Q4050	Cast supplies unlisted	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
Q4051	Splint supplies misc	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
Q4082	Drug/bio NOC part B drug CAP	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.	–	–	–
Q4100	Skin substitute NOS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
Q4101	Apligraf	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
Q4102	Oasis wound matrix	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
Q4103	Oasis burn matrix	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4104	Integra BMWD	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4105	Integra drt or omnigraft	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
Q4106	Dermagraft	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
Q4107	Graftjacket	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
Q4108	Integra matrix	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
Q4110	Primatrix	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4111	Gammagraft	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4112	Cymetra injectable	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4113	Graftjacket xpress	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4114	Integra flowable wound matri	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
Q4115	Alloskin	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4116	Alloderm	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
Q4117	Hyalomatrix	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4118	Matristem micromatrix	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4121	Theraskin	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4122	Dermacell awm porous sq cm	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
Q4123	ALLOSKIN RT PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4124	OASIS ULTRA TRI-LAYER WOUND MATRIX PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4125	ARTHROFLEX PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4126	Memoderm/derma/tranz/integup	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4127	TALYMED PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–

Q4128	Flexhd/allopatchhd/sq cm	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
Q4130	STRATTICE TM PER SQUARE CENTIMETER	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4132	Grafix core grafixpl core	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
Q4133	Grafix stravix prime pl sqcm	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
Q4134	hMatrix	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4135	Mediskin	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4136	EZderm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4137	Amnioexcel biodexcel 1sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4138	Biodfence dryflex 1cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4139	Amnio or biodmatrix inj 1cc	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4140	Biodfence 1cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4141	Alloskin ac 1 cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4142	Xcm biologic tiss matrix 1cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4143	Repriza 1cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4145	Epifix inj 1mg	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4146	Tensix 1cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4147	Architect ecm px fx 1 sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4148	Neox neox rt or clarix cord	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4149	Excellagen 0.1 cc	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4150	Allowrap ds or dry 1 sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4151	Amnioband guardian 1 sq cm	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
Q4152	Dermapure 1 square cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4153	Dermavest plurivest sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4154	Biovance 1 square cm	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
Q4155	Neoxflo or clarixflo 1 mg	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4156	Neox 100 or clarix 100	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4157	Revitalon 1 square cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4158	Kerecis omega3 per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4159	Affinity1 square cm	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
Q4160	Nushield 1 square cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4161	Bio-connekt per square cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4162	Wndex flw bioskn flw 0.5cc	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4163	Woundex bioskin per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4164	Helicoll per square cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4165	Keramatrix Kerasorb sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4166	Cytal per square centimeter	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4167	Truskin per sq centimeter	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4168	Amnioband 1 mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
Q4169	Artacent wound per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4170	Cygnus per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4171	Interfyl 1 mg	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4173	Palingen or palingen xplus	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4174	Palingen or promatrx	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4175	Miroderm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4176	Neopatch or therion per square centimeter	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4177	Floweramnioflo 0.1 cc	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4178	Floweramniopatch per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4179	Flowerderm per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4180	Revita per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4181	Amnio wound per square cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–

Q4182	Transcyte per sq centimeter	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4183	Surgigraft 1 sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4184	Cellesta or duo per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4185	Cellesta flowab amnion 0.5cc	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4186	Epifix 1 sq cm	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
Q4187	Epicord 1 sq cm	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
Q4188	Amnioarmor 1 sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4189	Artacent ac 1 mg	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4190	Artacent ac 1 sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4191	Restorigin 1 sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4192	Restorigin 1 cc	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4193	Coll-e-derm 1 sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4194	Novachor 1 sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4195	Puraply 1 sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4196	Puraply am 1 sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4197	Puraply xt 1 sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4198	Genesis amnio membrane 1sqcm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4199	Cygnus matrix per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4200	Skin te 1 sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4201	Matrion 1 sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4202	Keroxx (2.5g/cc) 1cc	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4203	Derma-gide 1 sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4204	Xwrap 1 sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4205	Membrane graft or wrap sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4206	Fluid flow or fluid gf 1 cc	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4208	Novafix per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4209	Surgraft per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4210	Axolotl graf dualgraf sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4211	Amnion bio or axobio sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4212	Allogen per cc	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4213	Ascent 0.5 mg	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4214	Cellesta cord per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4215	Axolotl ambient cryo 0.1 mg	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4216	Artacent cord per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4217	Woundfix biowound plus xplus	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4218	Surgicord per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4219	Surgigraft dual per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4220	Bellacell HD Surederm sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4221	Amniowrap2 per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4222	Progenamatrix per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4224	Hhf10-p per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4225	Amniobind per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4227	Amniocore per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4229	Cogenex amnio memb per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4230	Cogenex flow amnion 0.5 cc	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4231	Corplex p per cc	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4232	Corplex per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4233	Surfactor /nudyn per 0.5 cc	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4234	Xcellerate per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
Q4235	Amniorepair or altiply sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–

Q4236	Carepatch per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4237	Cryo-cord per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4238	Derm-maxx per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4239	Amnio-maxx or lite per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4240	Corecyte topical only 0.5 cc	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4241	Polycyte topical only 0.5cc	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4242	Amniocyte plus per 0.5 cc	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4244	Procenta per 200 mg	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4245	Amniotext per cc	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4246	Coretext or protext per cc	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4247	Amniotext patch per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4248	Dermacyte amn mem allo sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4249	Amniply per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4250	Amnioamp-mp per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4251	Vim per square centimeter	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4252	Vendaje per square centimet	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4253	Zenith amniotic membrane psc	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4254	Novafix dl per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4255	Reguard topical use per sq	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4256	Mlg complet per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4257	Relese per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4258	Enverse per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4259	Celera per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4260	Signature apatch per sq cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4261	Tag per square centimeter	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4262	Dual layer impax per sq cm	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	1/1/2023	_	Add effective 01/01/2023
Q4263	Surgraft tl per sq cm	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	1/1/2023	_	Add effective 01/01/2023
Q4264	Cocoon membrane per sq cm	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	1/1/2023	_	Add effective 01/01/2023
Q5009	Hospice care NOS	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
Q5103	Injection inflectra	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
Q5104	Injection renflexis	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
Q5109	Injection ixifi 10 mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
Q5124	Inj. byooviz 0.1 mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q5125	Inj releuko 1 mcg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
Q9004	Va whole health partner serv	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
Q9982	flutemetamol f18 diagnostic	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q9983	florbetaben f18 diagnostic	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S0013	Esketamine nasal spray	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S0122	Inj menotropins 75 iu	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S0126	Inj follitropin alfa 75 iu	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S0128	Inj follitropin beta 75 iu	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S0155	Epoprostenol dilutant	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S0157	Becaplermin gel 1% 0.5 gm	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
S0189	Testosterone pellet 75 mg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
S0194	Dialysis/Stress Vitamin Supplement Oral100 Capsules	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S0197	Prenatal vitamins 30 day	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S0207	Paramedicintercep nonhospals	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S0209	WC van mileage per mi	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S0215	Nonemerg transp mileage	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S0257	End of life counseling	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_

S0315	Disease management program	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S0316	Follow-up/reassessment	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S0317	Disease mgmt per diem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S0320	RN telephone calls to DMP	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S0390	Rout foot care per visit	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S0510	Non-prscrp lens	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S0514	Color cont lens	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S0516	Safety frames	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S0518	Sunglass frames	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S0590	Misc integral lens serv	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
S0596	Phakic iol refractive error	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S0622	Phys exam for college	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S0800	Laser in situ keratomileusis	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S0810	Photorefractive keratectomy	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S0812	Phototherap keratect	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S1001	Deluxe item	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
S1002	Custom item	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
S1030	Gluc monitor purchase	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S1031	Gluc monitor rental	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S1034	Art pancreas system	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S1035	Art pancreas inv disp sensor	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S1036	Art pancreas ext transmitter	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S1037	Art pancreas ext receiver	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S1040	Cranial remolding orthosis	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S1091	Stent non-coronary propel	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S2080	Laup	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S2083	Adjustment gastric band	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S2095	Transcath emboliz microspher	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S2102	Islet cell tissue transplant	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S2103	Adrenal tissue transplant	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S2107	Adoptive immunotherapy	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S2112	Knee arthroscp harv	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S2117	Arthroereisis subtalar	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
S2140	Cord blood harvesting	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S2142	Cord blood-derived stem-cell	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S2150	BMT harv/transpl 28d pkg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S2202	Echosclerotherapy	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S2230	Implant semi-imp hear	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S2235	Implant auditory brain imp	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S2300	Arthroscopy shoulder surgi	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
S2348	Decompress disc RF lumbar	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S2400	Fetal surg congen hernia	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S2401	Fetal surg urin trac obstr	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S2402	Fetal surg cong cyst malf	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S2403	Fetal surg pulmon sequest	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S2404	Fetal surg myelomeningo	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S2405	Fetal surg sacrococ teratoma	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S2409	Fetal surg noc	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
S2411	Fetoscop laser ther TTTS	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S3650	Saliva test hormone level;	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
S3652	Saliva test hormone level;	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
S3655	Antisperm antibodies test	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S3722	Dose Optimization By Area Under The Curve (Auc) Analysis, For Infusional 5-Fluorouracil	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

S3900	Surface EMG	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
S4005	Interim labor facility globa	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4011	IVF package	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4013	Compl GIFT case rate	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4014	Compl ZIFT case rate	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4015	Complete IVF nos case rate	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.	_	_	_
S4016	Frozen IVF case rate	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4017	IVF canc a stim case rate	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4018	F EMB trns canc case rate	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4020	IVF canc a aspir case rate	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4021	IVF canc p aspir case rate	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4022	Asst oocyte fert case rate	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4023	Incompl donor egg case rate	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4025	Donor serv IVF case rate	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4026	Procure donor sperm	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4027	Store prev froz embryos	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4028	Microsurg epi sperm asp	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4030	Sperm procure init visit	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4031	Sperm procure subs visit	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4035	Stimulated IUI case rate	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4037	Cryo embryo transf case rate	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4040	Monit store cryo embryo 30 d	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4042	Ovulation mgmt per cycle	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4990	Nicotine patch legend	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4991	Nicotine patch nonlegend	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4995	Smoking cessation gum	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5100	Adult daycare services 15min	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5101	Adult day care per half day	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5102	Adult day care per diem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5105	Centerbased day care perdiem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5108	Homecare train pt 15 min	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5109	Homecare train pt session	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5110	Family homecare training 15m	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5111	Family homecare train/sessio	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5115	Nonfamily homecare train/15m	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5116	Nonfamily HC train/session	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5120	Chore services per 15 min	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5121	Chore services per diem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5125	Attendant care service /15m	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5126	Attendant care service /diem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5130	Homaker service nos per 15m	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.	_	_	_
S5131	Homemaker service nos /diem	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.	_	_	_
S5135	Adult companioncare per 15m	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5136	Adult companioncare per diem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5140	Adult foster care per diem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5141	Adult foster care per month	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5145	Child fostercare th per diem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5146	Ther fostercare child /month	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5150	Unskilled respite care /15m	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5151	Unskilled respitecare /diem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5160	Emer response sys instal&tst	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5161	Emer rspns sys serv permonth	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5162	Emer rspns system purchase	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5165	Home modifications per serv	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5170	Homedelivered prepared meal	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5175	Laundry serv ext prof /order	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5181	HH respiratory thrpy nos/day	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
S5185	Med reminder serv per month	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5199	Personal care item nos each	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.	_	_	_
S5497	HIT cath care noc	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
S8035	Magnetic source imaging	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S8040	Topographic brain mapping	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S8080	Scintimammography	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S8130	INTERFERENTIAL CURRENT STIMULATOR 2 CHANNEL	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
S8131	INTERFERENTIAL CURRENT STIMULATOR 4 CHANNEL	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
S8185	Flutter device	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S8189	Trach supply noc	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
S8270	Enuresis alarm	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S8301	Infect control supplies NOS	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_

S8930	Auricular electrostimulation	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
S8940	Hippotherapy per session	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
S8948	Low-level laser trmt 15 min	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
S8990	Pt or manip for maint	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
S9001	Home uterine monitor with or	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
S9055	Procuren or other growth fac	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
S9056	Coma stimulation per diem	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
S9090	Vertebral axial decompressio	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	–	–	–
S9117	Back school visit	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
S9125	Respite care in the home p	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
S9128	Speech therapy in the home	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
S9129	Occupational therapy in the	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
S9131	PT in the home per diem	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
S9145	Insulin pump initiation	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
S9335	HT hemodialysis diem	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
S9340	HIT enteral per diem	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
S9341	HIT enteral grav diem	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
S9342	HIT enteral pump diem	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
S9343	HIT enteral bolus nurs	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
S9355	HIT chelation diem	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
S9364	HIT tpn total diem	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
S9366	HIT tpn 2 liter diem	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
S9367	HIT tpn 3 liter diem	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
S9368	HIT tpn over 3l diem	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
S9379	HIT noc per diem	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	–	–	–
S9381	HIT high risk/escort	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
S9401	Anticoag clinic per session	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
S9430	Pharmacy comp/disp serv	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
S9432	Med food non inborn err meta	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
S9434	Mod solid food suppl	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
S9435	Medical foods for inborn err	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	–	–	–
S9436	Lamaze class	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
S9437	Childbirth refresher class	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
S9438	Cesarean birth class	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
S9439	VBAC class	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
S9441	Asthma education	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
S9442	Birthing class	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
S9444	Parenting class	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	–	–	–
S9445	PT education noc individ	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.	–	–	–