## 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,

- 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							
	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.						
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.	-	-	_			
1055	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.	-	-	_			
1056	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.	-	-	-			
1057	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.	-	-	_			
1200	REMOVAL OF SKIN TAGS <w 15<="" td=""><td>Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.</td><td>-</td><td>-</td><td>_</td></w>	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	_			
201	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.	-	-	_			
1719	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.	_	_	_			
1920	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.	-	_	_			
1921	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.	-	-	_			
.922	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.	-	-	_			
950	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.	-	-	_			
951	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.	-	-	-			
952	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.	-	-	-			
1954	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.	-	-	-			
1960	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-		-
11982	Remove Drug Implant Device	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
11983	REMOVE/INSERT DRUG IMPLANT	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	4/1/2023		Add effective 04/01/2023
		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
15274	Skn Sub Grft T/A/L Child Add	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	4/1/2023	-	Add effective 04/01/2023
15275	Skin Sub Graft Face/Nk/Hf/G	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	4/1/2023		Add effective 04/01/2023
		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	,,,,,,,,,,,		
15758	FREE FASCIAL FLAP MICROVASC	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a		-	-
15769	GRFG AUTOL SOFT TISS DIR EXC	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	_	_	_
15775	HAIR TRNSPL 1-15 PUNCH GRFTS	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_	-	-
15776	HAIR TRNSPL >15 PUNCH GRAFTS	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
15780	DERMABRASION TOTAL FACE	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	_	_	_
15783	DERMABRASION SUPRFL ANY SITE	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
15786	ABRASION LESION SINGLE	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
15787	ABRASION LESIONS ADD-ON	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			
	CHEMICAL PEEL NONFACIAL	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-		-
15793		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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
15820	REVISION OF LOWER EYELID	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
15821	REVISION OF LOWER EYELID	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a		_	
15828	REMOVAL OF FACE WRINKLES	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
15829	REMOVAL OF SKIN WRINKLES	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a		_	=
15834	EXCISE EXCESSIVE SKIN HIP	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_	-	-
15835	EXCISE EXCESSIVE SKIN BUTTCK	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	_	_	_
15839		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	_	=
	EXCISE EXCESS SKIN & TISSUE	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
15847	EXC SKIN ABD ADD-ON	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	_	_	_
17107	DESTRUCTION OF SKIN LESIONS	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a		-	-
17108	DESTRUCTION OF SKIN LESIONS	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	_	_	_
47200	LIAID DEMOVAL BY ELECTROLYCIC	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
17380	HAIR REMOVAL BY ELECTROLYSIS	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			_
19105	CRYOSURG ABLATE FA EACH	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			
	DDEACT ALICMENTATION W/MADIT	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
19325	BREAST AUGMENTATION W/IMPLT	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
19328	RMVL INTACT BREAST IMPLANT	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
19342	INSJ/RPLCMT BRST IMPLT SEP D	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	_	_	_
19357	TISS XPNDR PLMT BRST RCNSTJ	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			_
19557	1133 APINDR PLIVIT BRST RCNSTJ	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
19370	REVJ PERI-IMPLT CAPSULE BRST	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			-
20527	INJ DUPUYTREN CORD W/ENZYME	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-	_	_	_
20979	US BONE STIMULATION	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a		-	-
20982	ABLATE BONE TUMOR(S) PERQ	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			
21089	UNLISTED MAXLECL PROSTH PX	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.			-
24420		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	_	-
21120	RECONSTRUCTION OF CHIN	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
21121	RECONSTRUCTION OF CHIN	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-		-
21244	RECONSTRUCTION OF LOWER JAW	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_		-
21248	RECONSTRUCTION OF JAW	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	_	_	_
21742	Repair Stern/Nuss W/O Scope	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
21743	Repair Sternum/Nuss W/Scope	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).	_	_	
		nembersacie Experimental, investigational analytic outploved services (EIO).			

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-			
22380	ANTINO FRE-SAC NINBOT ES-SI	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
22867	INSJ STABLJ DEV W/DCMPRN	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-			
	INSU STABLU DEV W/O DCIVIFRIN	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
22870	INSJ STABLJ DEV W/O DCMPRN	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
23929	UNLISTED PROCEDURE SHOULDER	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	_		_
25999	UNLISTED PX FOREARM/WRIST	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.		_	-
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
26340	MANIPULATE FINGER W/ANESTH	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	_	-
27280	ARTHR SI JT OPN B1GRF INSTRM	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			-
27703	RECONSTRUCTION ANKLE JOINT	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	_		_
27899	UNLISTED PX LEG/ANKLE	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.			-
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 PX CASTING/STRPG	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.  Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	-	-	-
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria: BCBSOK recommends submitting a	_	-	-
29862	HIP ARTHRO W/DEBRIDEMENT	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	_	_	_
29868	MENISCAL TRNSPL KNEE W/SCPE	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
23808	WENISCAL TRIASPERIVEE WYSEFE	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
29914	HIP ARTHRO W/FEMOROPLASTY	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
29999	UNLISTED PX ARTHROSCOPY	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-	1/1/2023		Add effective 01/01/2023
30999	UNLISTED PROCEDURE NOSE	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Unlisted Procedure; May require Prior Authorization per contract agreement.		_	, , , , , , , , , , , , , , , , , ,
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_	-	-
31295	NsI/Sins Ndsc Surg Max Sins	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
31298	NsI/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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
31574	Largsc W/Njx Augmentation	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
31647	BRONCHIAL VALVE INIT INSERT	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	_	_	_
	PRONCHIAL VALVE ADDL INCEST	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
31651	BRONCHIAL VALVE ADDL INSERT	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Citation Precedure (consists reviewed to preum each consists mosts BCBSOK Medical Policy criteria). BCBSOK recommends submitting a	-	-	-
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.	-	-	_
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Modern   M	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		_	_	_
April   Proceedings   Process   Pr	32553	Ins Mark Thor For Rt Perq	· · · · · · · · · · · · · · · · · · ·	-	-	-
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March 1997   Control Prop.	32994	ABLATE PULM TUMOR PERO CRYBL	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
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Metal   March   Marc		·		-	-	-
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	33211	INSERT CARD ELECTRODES DUAL	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
	33213	INSERT PULSE GEN DUAL LEADS	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
Main	33225	L VENTRIC PACING LEAD ADD-ON		-	_	-
1982   1982	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	_	_	_
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	33269	EXCL LAA THRSCP ANY METHOD	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
March September 19   Control	33270	Ins/Rep Subq Defibrillator		-	-	-
March   National Prince   Na	33271	Insj Subq Impltbl Dfb Elctrd		_	_	_
Justine of email (as) in why (in) and carbon for the control of th	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	_	_	_
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PARKA JANIC WAVE ON   Received from the received in each of the section medical flowly or three. In 1805 or the received in the control of the parkage of	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	_	_	_
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## SECONDAY OF THE PROPERTY OF	33362	REPLACE AURTIC VALVE OPEN	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
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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	_	_	_
38211	TUMOR CELL DEPLETE OF HARVST	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
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38212	RBC DEPLETION OF HARVEST	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			
50215	THINKEST STEM CEEL CONCERNING	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
38230	BONE MARROW HARVEST ALLOGEN	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			
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38240	TRANSPLT ALLO HCT/DONOR	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
38242	TRANSPLT ALLO LYMPHOCYTES	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
38243	TRANSPLI 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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	_
41120	Partial Removal Of Tongue	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-	_	_	_
41599	UNLISTED PX TONGUE FLR MOUTH	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  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	_	_	_
42145	REPAIR PALATE PHARYNX/UVULA	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
42299		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.		_	-
42299	UNLISTED PX PALATE UVULA 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.  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			_
43201	Esoph Scope W/Submucous Inj	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_		
43201	Esoph Scope W/Submucous Inj	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
43206	ESOPH OPTICAL ENDOMICROSCOPY	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	_	_	_
43252	EGD OPTICAL ENDOMICROSCOPY	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			
		Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
43253	EGD US TRANSMURAL INJXN/MARK	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_	_	-
43289	UNLISTED LAPS PX ESOPH	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 or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
43633	REMOVAL OF STOMACH PARTIAL	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	_	_	_
43659	UNLISTED LAPS PX STOMACH	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.		_	_
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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_	_	-
43771	LAP REVISE GASTR ADJ DEVICE	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.	_	_	-
		, and the second			

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.	_	_	_
42775	LAD CLEEVE CACEDECTOAN	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
43775	LAP SLEEVE GASTRECTOMY	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			
43043	GASTROLEASTI W/O V BAND	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/conice reviewed to preuro each conice meets PCBSOK Medical Policy criteria. PCBSOK recommends submitting a	-	-	-
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			
15010	G1511110 51171551 ON 0525111	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			
15010	NEVISION G/BINGI BIBIT	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	_
43860	Revise Stomach-Bowel Fusion	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			
15000	NEVISE GASTING FOR GASTIN	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	_
43887	REMOVE GASTRIC PORT OPEN	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
44640	Repair Bowel-Skin Fistula	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.			
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			-
47370	LAPARO ABLATE LIVER TUMOR RF	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.	_	_	_
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
47381	Open Ablate Liver Tumor Cryo	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
49412	Ins Device For Rt Guide Open	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			-
50360	TRANSPLANTATION OF KIDNEY	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			_
50542	LAPARO ABLATE RENAL MASS	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
50593	PERC CRYO ABLATE RENAL TUM	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.			<del>-</del>
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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
52287	Cystoscopy Chemodenervation	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
52441	CYSTOURETHRO W/IMPLANT	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			_
53855	INSERT PROST URETHRAL STENT	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-	_	_	_
53899	UNLISTED PX URINARY SYSTEM	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.			
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria: BCBSOK recommends submitting a	-	-	-
54110	Treatment Of Penis Lesion	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	<u>-</u>

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			
34112	Treat renis tesion drait	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
54205	TREATMENT OF PENIS LESION	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			
31210	12.113.510.51	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-		
54360	Penis Plastic Surgery	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			
34401	INSERT SEET-CONTO PROSTITESIS	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
54405	INSERT MULTI-COMP PENIS PROS	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	_	_	_
E 4 4 0 0	DEDAID MALILEL COMAD DENIIS DDOS	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
54408	REPAIR MULTI-COMP PENIS PROS	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			-
54415	REMOVE SELF-CONTD PENIS PROS	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
54660	REVISION OF TESTIS	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
55876	Place Rt Device/Marker Pros	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
55980	SEX TRANSFORMATION F TO M	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			-
57291	CONSTRUCTION OF VAGINA	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
57296	REVISE VAG GRAFT OPEN ABD	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			
5,333	NEI AIII VAOIIVA	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
57426	REVISE PROSTH VAG GRAFT LAP	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.			-
58976 58999	Transfer Of Embryo 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.	-	_	-
	•		<u>-</u>	<u>-</u>	-
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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-

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-			
61645	PERQ ART M-THROMBECT &/NFS	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a		_	_
		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	_	-
61650	Evasc Pring Admn Rx Agnt 1St	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
61651	Evasc Pring 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	_	_	_
62263	EPIDURAL LYSIS MULT SESSIONS	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			
		Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
62264	EPIDURAL LYSIS ON SINGLE DAY	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	_	_	_
64566	Neuroeltrd Stim Post Tibial	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-		-
64568	OPN IMPLTJ CRNL NRV NEA&PG	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	_	_	_
64590	INSRT/REDO PN/GASTR STIMUL	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-		-
64615	Chemodenerv Musc Migraine	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	_	-
64624	DSTRJ NULYT AGT GNCLR NRV	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
64650	Chemodenerv Eccrine Glands	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-		-
64653	Chemodenerv Eccrine Glands	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			
64818	Remove Sympathetic Nerves	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_		
		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-		-
64820	Sympathectomy Digital Artery	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	_		_
65755	Corneal Transplant	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	*	
		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-		-
65756	Corneal Trnspl Endothelial	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	_	-
65767	CORNEAL TISSUE TRANSPLANT	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-		_
65770	REVISE CORNEA WITH IMPLANT	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.  Modical Policy Citaria: Procedure/consists evaluated to accura each consists mode PCBSOK Modical Policy citaria. PCBSOK recommends submitting a	_	_	_
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.	_	_	_
		necommended chinical neview (i reducermination) request it it is unclear it the service meets bebook intended 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			
00173	TREDIVIE DIE AQ O/F CAN W/31	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
66179	AQUEOUS SHUNT EYE W/O GRAFT	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
66184	Revision Of Aqueous Shunt	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	_		_
	VOLDE CTROPING INC.	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
66991	XCAPSL CTRC RMVL INSJ 1+	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	_
67027	Implant Eye Drug System	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a		_	
67225	Eye Photodynamic Ther Add-On	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 67599	UNLISTED PX EXTRAOCULAR MUSC UNLISTED PROCEDURE ORBIT	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	-	_	-
		Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	_	-
67901	REPAIR EYELID DEFECT	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a		_	
67904	REPAIR EYELID DEFECT	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	_	_	_
67999	UNLISTED PROCEDURE EYELIDS	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.			
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	_	_	_
60200	REVISE EXTERNAL EAR	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
69300		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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
69676	Remove Middle Ear Nerve	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_	_	-
69716	IMPL OI IMPLT SK TC ESP<100	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	1/1/2023	_	Add effective 01/01/2023
69729	IMPLOLIMANT SY TO FOR-100	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	1/1/2022		Add offeetive 01/01/2022
09729	IMPL OI IMPLT SK TC ESP>=100	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	1/1/2023	-	Add effective 01/01/2023
69730	RPLC OI IMPLT SK TC ESP>=100	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
75894	X-Rays Transcath Therapy	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
75958	Xray Place Prox Ext Thor Ao	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
76125	CINE/VIDEO X-RAYS ADD-ON	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.  Modical Ballicy Citatria: Procedure/service reviewed to accurage and sequences and sequences and sequences are sequences.	_	_	_
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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
76940	US GUIDE TISSUE ABLATION	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.	-	_	-
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
77299	UNLISTED PX THER RAD TX PLNG	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.	-	-	-
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
77399	UNLISTED PX MED RADJ PHYSICS	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.	-	-	-
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
77499	UNLISTED PX THER RAD TX MGMT	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.	-	-	-
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
77799	UNLISTED PX CLIN BRACHYTX	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			
78499		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-		-
78599	UNLISTED CV PX DX NUC MED 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.  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			
79999	RP THERAPY UNLISTED PX	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.			_
80299	QUANTITATIVE ASSAY DRUG	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.  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	-	-	-
91101	Dilid Dup/Delet Allalysis	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
81206	Bcr/Abl1 Gene Major Bp	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	_	_	_
04244	FF Com-	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
81241	F5 Gene	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				
81479	ONLISTED WOLLECOLAR PATHOLOGY	Unlisted Procedure; May require Prior Authorization per contract agreement.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
81490	Autoimmune Rheumatoid Arthr	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			
81307	retal Alleupiolog Hisolii Kisk	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
81535	Oncology Gynecologic	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			
01550	Oncology Eurig	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-		-
81539	Oncology Prostate Prob Score	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.			
01333	ONLISTES HAVE	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			-
83006	Growth Stimulation Gene 2	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).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			
83701	LIPOPROTEIN BLD HR FRACTION	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).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-		_	=
83937	ASSAY OF OSTEOCALCIN	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).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			
84431	THROMBOXANE URINE	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-	_	_	_
86343	LEUKOCYTE HISTAMINE RELEASE	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			
		Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
86352	Cell Function Assay W/Stim	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	_		_	
86486	SKIN TEST UNLISTED ANTIGN EA	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.				
86849	IMMUNOLOGY PROCEDURE		-	-	-	
		Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.  New Coursel Procedure/service not severed by PCRSOV. Not subject to utilization review.	-		-	
86910	BLOOD TYPING PATERNITY TEST	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	_	
86950	Leukacyte Transfusion	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-			
87506	IADNA-DNA/RNA PROBE TQ 6-11	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				
89251	Cultr Obcyte/Embryo <4 Days	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.  Non Covered Decedure/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.	_	_	_	
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a				
89291	Biopsy Oocyte Polar Body	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.	-	_	_	
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a				
90283	HUMAN IG IV	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a				
90284	HUMAN IG SC	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.				
30378	NOV INIO INI DOINIO	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.			<del>-</del>	
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_	-	-	
90664	Laiv Vacc Pandemic Intranasl	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.	_	_	_	
1						
0000	IIIVAVACC DANIDENAIC ACTURE	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a				
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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_	_	_
90867	TCRANIAL MAGN STIM TX PLAN	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_	_	-
90869	TCRAN MAGN STIM REDETEMINE	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	_	_	_
00075	POLICIA DE LA COLONIA DE LA CO	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
90875	PSYCHOPHYSIOLOGICAL THERAPY	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
90901	BIOFEEDBACK TRAIN ANY METH	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
90913	BFB TRAINING EA ADDL 15 MIN	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			
21022	o Esopii neiix ist w/clectron	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Modical Policy Criteria: Precedure/conice policy and to posture each sonice meets PCBSOK 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.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
91065	BREATH HYDROGEN/METHANE TEST	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			
91111	GI TRC IMG INTRAL ESOPHAGUS	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			_
91112	GI WIRELESS CAPSULE MEASURE	Reimbursable Experimental, Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			
31112	GI WINELESS CAI SOLE WEASONE	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
91113	GI TRC IMG INTRAL COLON I&R	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-	_	_	_
		EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
91133	ELECTROGASTROGRAPHY W/TEST	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	-	 -	-
		Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by 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: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	- -	-	- - -
91133	ELECTROGASTROGRAPHY W/TEST	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by 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: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	- - -	- - -	-
91133 91299 92065	ELECTROGASTROGRAPHY W/TEST  UNLISTED DX GI PROCEDURE  ORTHOP TRAING PFRMD PHYS/QHP	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by 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: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	- - -	- - -	-
91133 91299	ELECTROGASTROGRAPHY W/TEST  UNLISTED DX GI PROCEDURE	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by 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: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	- - - -	- - - -	- - - -
91133 91299 92065	ELECTROGASTROGRAPHY W/TEST  UNLISTED DX GI PROCEDURE  ORTHOP TRAING PFRMD PHYS/QHP	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by 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: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	- - - -	- - - -	- - - -
91133 91299 92065 92066	ELECTROGASTROGRAPHY W/TEST  UNLISTED DX GI PROCEDURE  ORTHOP TRAING PFRMD PHYS/QHP  ORTHOP TRAING SUPVI PHYS/QHP	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by 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: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommend submitting a Recommend submitted in the service meets BCB		- - - -	- - - -
91133 91299 92065 92066 92132 92145	ELECTROGASTROGRAPHY W/TEST  UNLISTED DX GI PROCEDURE  ORTHOP TRAING PFRMD PHYS/QHP  ORTHOP TRAING SUPVJ PHYS/QHP  CMPTR OPHTH DX IMG ANT SEGMT  CORNEAL HYSTERESIS DETER	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by 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: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria.  BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by 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 91299 92065 92066 92132	ELECTROGASTROGRAPHY W/TEST  UNLISTED DX GI PROCEDURE  ORTHOP TRAING PFRMD PHYS/QHP  ORTHOP TRAING SUPVJ PHYS/QHP  CMPTR OPHTH DX IMG ANT SEGMT	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by 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: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.		- - - - -	- - - - -
91133 91299 92065 92066 92132 92145	ELECTROGASTROGRAPHY W/TEST  UNLISTED DX GI PROCEDURE  ORTHOP TRAING PFRMD PHYS/QHP  ORTHOP TRAING SUPVJ PHYS/QHP  CMPTR OPHTH DX IMG ANT SEGMT  CORNEAL HYSTERESIS DETER	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by 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: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.		-	- - - - -
91133 91299 92065 92066 92132 92145 92273 92274	ELECTROGASTROGRAPHY W/TEST  UNLISTED DX GI PROCEDURE  ORTHOP TRAING PFRMD PHYS/QHP  ORTHOP TRAING SUPVJ PHYS/QHP  CMPTR OPHTH DX IMG ANT SEGMT  CORNEAL HYSTERESIS DETER  Full Field Erg W/I&R  Multifocal Erg W/I&R	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by 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: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service to reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.			- - - - - -
91133 91299 92065 92066 92132 92145 92273 92274 92499	ELECTROGASTROGRAPHY W/TEST  UNLISTED DX GI PROCEDURE  ORTHOP TRAING PFRMD PHYS/QHP  ORTHOP TRAING SUPVJ PHYS/QHP  CMPTR OPHTH DX IMG ANT SEGMT  CORNEAL HYSTERESIS DETER  Full Field Erg W/I&R  Multifocal Erg W/I&R  UNLISTED OPH SVC/PROCEDURE	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by 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: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.			- - - - - -
91133 91299 92065 92066 92132 92145 92273 92274	ELECTROGASTROGRAPHY W/TEST  UNLISTED DX GI PROCEDURE  ORTHOP TRAING PFRMD PHYS/QHP  ORTHOP TRAING SUPVJ PHYS/QHP  CMPTR OPHTH DX IMG ANT SEGMT  CORNEAL HYSTERESIS DETER  Full Field Erg W/I&R  Multifocal Erg W/I&R	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by 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: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service not otherwise defined or classified, and may be subject to benefit	- - - - - -		- - - - - - -
91133 91299 92065 92066 92132 92145 92273 92274 92499	ELECTROGASTROGRAPHY W/TEST  UNLISTED DX GI PROCEDURE  ORTHOP TRAING PFRMD PHYS/QHP  ORTHOP TRAING SUPVJ PHYS/QHP  CMPTR OPHTH DX IMG ANT SEGMT  CORNEAL HYSTERESIS DETER  Full Field Erg W/I&R  Multifocal Erg W/I&R  UNLISTED OPH SVC/PROCEDURE	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by 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: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK 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.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and	-		- - - - - - -
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91133 91299 92065 92066 92132 92145 92273 92274 92499 92512 92517 92518	ELECTROGASTROGRAPHY W/TEST  UNLISTED DX GI PROCEDURE  ORTHOP TRAING PFRMD PHYS/QHP  ORTHOP TRAING SUPVI PHYS/QHP  CMPTR OPHTH DX IMG ANT SEGMT  CORNEAL HYSTERESIS DETER  Full Field Erg W/I&R  UNLISTED OPH SVC/PROCEDURE  NASAL FUNCTION STUDIES  VEMP TEST I&R CERVICAL  VEMP TEST I&R CCEVICAL  VEMP TST I&R CERVICAL&OCULAR	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by 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: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Submitted in Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK 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			
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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).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			-
93228	REMOTE 30 DAY ECG REV/REPORT	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			-
93261	Interrogate Subq Defib	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			-
93356	Myocrd Strain Img Spckl Trck	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			-
93641	Electrophysiology Evaluation	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
93660	TILT TABLE EVALUATION	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-			
33702	DIS ATTRICECE TESTS ATTAINETS	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-		-
93740	TEMPERATURE GRADIENT STUDIES	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_	_	-
93886	Intracranial Complete Study	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			-
93892	Tcd Emboli Detect W/O Inj	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-		_	_
04015	PATIENT RECORDED SPIROMETRY	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			
94015	PATIENT RECORDED SPIROWETRY	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
94016	REVIEW PATIENT SPIROMETRY	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	_	_	_
04774	Ded Herre Arress Des Consul	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
94774	Ped Home Apnea Rec Compl	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
94777	Ped Home Apnea Rec Report	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_	_	_
95027	Icut Allergy Titrate-Airborn	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_	_	_
95700	Eeg Cont Rec W/Vid Eeg Tech	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	_	-
95707	Eeg W/O Vid 2-12Hr Cont Mntr	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_	-	-
95710	Eeg W/O Vid Ea 12-26Hr Cont	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a		-	-
95713	Veeg 2-12 Hr Cont Mntr	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.	_	_	_
I .		necommended content neview (Fredetermination) request it it is unclear it the service meets be both inedical Policy Citieria.			

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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
95717	Eeg Phys/Qhp 2-12 Hr W/O Vid	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_	_	-
95720	Eeg Phy/Qhp Ea Incr W/Veeg	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
95723	Eeg Phy/Qhp>60<84 Hr W/O Vid	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	_	_	_
05726	Fog Dhy/Ohas 94 Hz W/Voog	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
95726	Eeg Phy/Qhp>84 Hr W/Veeg	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	_	_	_
95803	ACTIGRAPHY TESTING	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
93603	ACTIGNAPHT TESTING	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.	_	_	_
05000	DOLVCOM ANY ACE 4 2: DADAM	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
95808	POLYSOM ANY AGE 1-3> PARAM	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	_	_	_
95905	MOTOR &/ SENS NRVE CNDJ TEST	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			
95905	MOTOR &/ SENS NRVE CNDJ TEST	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	_	_	_
05057	For Digital Applysis	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
95957	Eeg Digital Analysis	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
95961	Electrode Stimulation Brain	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			
33303	MEG SI GIVINILEGGS	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	_	-
95966	MEG EVOKED SINGLE	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_	-	-
95971	Alys Smpl Sp/Pn Npgt W/Prgrm	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			
	74/3 3.1.pr c.1.14pgc 1.g.1.1.g	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
95977	Alys Cplx Cn Npgt Prgrmg	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	_	-
95983	Alys Brn Npgt Prgrmg 15 Min	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_	_	
96001	MOTION TEST W/FT PRESS MEAS	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_	_	-
96004	PHYS REVIEW OF MOTION TESTS	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	_	_
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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
96571	PHOTODYNAMIC TX ADDL 15 MIN	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
Laborate		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_	_	_
96573	Pdt Dstr Prmlg Les Phys/Qhp	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.			
96573	Pdt Dstr Prmig Les Phys/Qhp  Dbrdmt Prmig Les W/Pdt	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK 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			
30313	THOTOCHEMOTHEMAT TOVA ON D	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	_
96922	Laser Tx Skin >500 Sq Cm	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
96932	Rcm Celulr Subcelulr Img Skn	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 Celuir Subceluir Img Skn	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
30334	Keili Ceidii Subceidii illig Skii	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
96935	Rcm Celuir Subceluir Img Skn	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			
96999	UNLISTED SPEC DERM SVC/PX	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.			_
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.			
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			-
97024	Diathermy Eg Microwave	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
97533	Sensory Integration	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
97546	Work Hardening Add-On	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			
97606	Neg Press Woulid 1x >50 Cili	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.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			
97610	LOW FREQUENCY NON-THERMAL US	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.	-	-	-

		Modical Palicy Celegia, Decodyra Jespica reviewed to enture each conice mosts DCDCOV Modical Palicy estatic DCDCOV recommends submitting a			
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).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			_
0062U	AI SLE IGG&IGM ALYS 80 BMRK	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
0063U	NEURO AUTISM 32 AMINES ALG	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			-
0075T	PERQ STENT/CHEST VERT ART	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
0076T	S&I STENT/CHEST VERT ART	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-	_	_	_
0102T	ESW PHY ANES LAT HMRL EPCNDL	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			
		Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	_	-	-
0106T	TOUCH QUANT SENSORY TEST	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-	_	_	_
0109T	HEAT QUANT SENSORY TEST	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			_
		Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	_	_	-
0110T	NOS QUANT SENSORY TEST	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).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_		
0200T	PERQ SACRAL AUGMT UNILAT INJ	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	_	-
0201T	PERQ SACRAL AUGMT BILAT INJ	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			
	Audious Als O Boss	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_		
0209T	Audiometry Air & Bone	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
0210T	Speech Audiometry Threshold	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).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			_
0221T	PLMT POST FACET IMPLT LUMB	Reimbursable Experimental, Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
0222T	PLMT POST FACET IMPLT ADDL	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-		_	_
0264T	IM B1 MRW CEL THER XCL HRVST	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			_
		Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
0265T	IM B1 MRW CEL THER HRVST ONL	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-		
0269T	REV/REMVL CRTD SNS DEV TOTAL	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
0270T	REV/REMVL CRTD SNS DEV LEAD	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	_	_	_
0274T	PERQ LAMOT/LAM CRV/THRC	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			-
02/41	. End Envior/Enviolent/TIRC	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-	_	_	_
0308T	INSJ OCULAR TELESCOPE PROSTH	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy Criteria. BCBSOK recommends submitting a			
		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
0323U	ladna Cns Pthgn Next Gen Seq	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			
	TEAR FILM IMG UNI/BI W/I&R	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-		-
0330T	TEAR FILM IMG UNI/BI W/I&R	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
0331T	HEART SYMP IMAGE PLNR	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			-
0334U	ONC SLD ORGN TGSA DNA 84/+	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
0335T	INSJ SINUS TARSI IMPLANT	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	_	_	_
0337U	ONC PLSM CELL DOandMYELOMA ID	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
0338T	TRNSCTH RENAL SYMP DENRV UNL	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
0340U	ONC PAN CA ALYS MRD PLASMA	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	_	_	_
0343U	ONC PRST8 XOM ALY 442 SNCRNA	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
0344U	HEP NAFLD SEMIQ EVL 28 LIPID	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.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			-
0347T	INS BONE DEVICE FOR RSA	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			
	RSA UPPER EXTR EXAM	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			-
0349T	NSA OPPER EXTR EXAM	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
0349U	RX METAB/PCX DNA 27GEN RX IA	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
0351U	NFCT DS BCT/VIRAL TRAIL IP10	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
0352T	OCT BRST/NODE I&R PER SPEC	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	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
	PRB	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
0354U	HPV HI RSK QUAL MRNA E6/E7	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).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	_	=
0397T	ERCP W/OPTICAL ENDOMICROSCPY	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
0402T	COLGN CRS-LINK CRN&PACHYMTRY	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			
0411T	Insj/Rplc Car Modulj Vnt Elt	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_		
		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_	_	-
0412T	Rmvl Cardiac Modulj Pls Gen	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			
	Prgrmg Eval Cardiac Modulj	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			_
0417T		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_	_	-
0418T	Interro Eval Cardiac Modulj	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	_	2/28/2023	Remove effective 02/28/2023
0422T	TACTILE BREAST IMG UNI/BI	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
	<u> </u>	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			-
0424T	INSJ/RPLC NSTIM APNEA COMPL	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
0425T	INSJ/RPLC NSTIM APNEA SEN LD	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-			
0429T	RMVL NSTIM APNEA SEN LD	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			_
		Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	_	_	-
0430T	RMVL NSTIM APNEA STIMJ LD	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-			
0435T	PRGRMG EVAL NPGS APNEA 1 SES	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			_
		Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	_	-
0436T	PRGRMG EVAL NPGS APNEA STUDY	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	-	-	-
0440T	Abitj 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	_	_	_
0443T	R-T Spctrl Alys Prst8 Tiss	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-		-
0449T	INSJ AQUEOUS DRAIN DEV 1ST	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_	_	-
0450T	INSJ AQUEOUS DRAIN DEV EACH	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).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a		_	-
0474T	INSJ AQUEOUS DRG DEV IO RSVR	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
0481T	Njx Autol Wbc Concentrate	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-			_
0486T	OCT MID EAR I&R BILATERAL	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			
		Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
0489T	Regn Cell Tx Scldr Hands	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 & CANNULI 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	_	_	_
0496T	MNTR CDVR DON LNG EA ADDL HR	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
	NEAR IFR 2IMG MIBMN GLND I&R	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	_		-
0507T	ALAN II N ZIWIG IVIIDIVIN GLIND IĞK	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	-	-	-

		FILL Decoder / Control of the Delication of the			
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.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-		-
0511T	RMVL&RINSJ SINUS TARSI IMPLT	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
0512T	ESW INTEG WND HLG 1ST WND	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	_	_	_
0516T	INSJ WCS LV ELTRD ONLY	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	_	-
0517T	INSJ WCS LV PG COMPNT	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	_	_	_
0521T	Interrog Dev Eval Wcs Ip	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	_	-
0522T	Prgrmg Dev Eval Wcs Ip	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 lims	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK 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 lims Eltrd Only	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_	_	_
0527T	Insj/Rplcmt lims Implt Mntr	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_	_	-
0528T	Prgrmg Dev Eval lims Ip	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 lims	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK 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 lims 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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			-
0532T	Removal lims Implt Mntr Only	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
0533T	CONT REC MVMT DO 6-10 DAYS	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).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			-
0537T	Bld Drv T Lymphcyt Car-T Cll	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
0538T	Bld Drv T Lymphcyt Prep Trns	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 CII 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			
0547T	B1 Matrl Qual Tst Mcrind Tib	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  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.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			-
0563T	EVAC MEIBOMIAN GLND HEAT BI	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
0565T	AUTOL CELL IMPLT ADPS HRVG	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a		-	-
0589T	ELEC ALYS SMPL PRGRMG IINS	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
0590T	ELEC ALYS CPLX PRGRMG IINS	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).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	_	-	_
0620T	EVASC VEN ARTLZ TIBL/PRNL VN	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
0621T	TRABECULOSTOMY INTERNO LASER	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).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	_	-	-
0625T	AUTO QUAN C PLAQ CPTR ALYS	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-			
0629T	PERQ NJX ALGC CT LMBR 1ST	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			
		Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
0630T	PERQ NJX ALGC CT LMBR EA	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-	_	_	_
0641T	NCNTC NR IFR SPCTRSC WND IMG	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			
0642T	NCNTC NR IFR SPCTRSC WND I&R	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			-
		Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
0643T	TCAT L VENTR RSTRJ DEV IMPLT	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-	1/1/2023	_	Add effective 01/01/2023
0656T	VRT BDY TETHERING ANT <7 SEG	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			
		Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			-
0657T	VRT BDY TETHERING ANT 8+ SEG	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
0658T	Elec Impd Spectrsc 1+Skn Les	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-	_	_	_
0668T	BKBENCH PREP DON UTER ALGRFT	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			
		Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
0669T	BKBENCH RCNSTJ DON UTER VEN	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
0670T	BKBENCH RCNSTJ DON UTER ARTL	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			
0717T	Adrc Ther Prtl Rc Tear	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
0718T	Adrc Ther Prtl Rc Tear Njx	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
0719T	Pst Vrt Jt Rplcmt Lmbr 1 Sgm	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	_	_	_
0724T	Qmrcp W/Dx Mri Same Anatomy	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	*		
		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a		-	-
0725T	Vestibular Dev Impltj Uni	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
0726T	Rmvl Implt Vstibular Dev Uni	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	_	_	_
0731T	Augmnt Ai-Based Fcl Phnt A/R	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	_	
		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_	-	-
0732T	Immntx Admn Electroporatn Im	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
0733T	Rem Bdyandimb Knmtc Ther Sply	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 lort 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	_	_	_
I		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.			

		EIII: Procedure/conice not reimburged by BCDCOV. Not subject to utilization review. Places one the Clinical Payment and Codics Della Mark No.			
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	INSTLI 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
783T	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
0795Т	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 (e.g., 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
0796Т	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
0797Т	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	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
0800Т	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

A0426	Als 1 Ambulance Service Advanced Life	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	_	-
A0426	Als 1				
	. , ,	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
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.	-	-	-
A0210	Noner transport meals escort	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.	_	_	_
A0190	Noner transport meals recip	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.	-	_	_
A0170	Transport parking fees/tolls	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
A0140 A0160	Nonemergency transport air  Noner transport case worker	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  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.	-	-	-
A0120	Noner transport mini-bus	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.	_	_	_
A0100	Nonemergency transport taxi	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.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	-
A0021 A0080	Noninterest escort in non er	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	-	-
9701A A0021	NON-PRESCRIPTION DRUGS Outside state ambulance serv	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	-	_
0810T	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
	preparation and transmission, quantification of pulmonary tissue ventilation, data review, interpretation and report Subretinal injection of a				
0808T	the purpose of pulmonary tissue ventilation analysis, including data	EIU: Procedure/service not reimbursed by 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
0807Т	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 BCBSOX. 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
D806T	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
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
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
0803Т	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
0802T	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
	Transcatheter removal and				

A0428	Ambulance Service Basic Life Support Non-Emergency Transport (Bis)	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK 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	_	_	_
A0432	Paramedic Intercept (Pi) Rural Area Transport Furnished By A Volunteer Ambulance Company Which Is Prohibited By State Law From Billing	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	-	-
A0435	Third Party Payers 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		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			_
A0999	No Transport Unlisted ambulance service	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.			_
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).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	_	-
A2002	Mirragen adv wnd mat per sq	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-	_	_	_
A2006	Novosorb synpath per sq cm	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			
A2000	NOVOSOID SYMPACTI PET SQ CITI	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	_	-
A2007	Restrata per sq cm	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-	_	_	_
A2010	Apis per square centimeter	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			
		Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
A2011	Supra sdrm per sq cm	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).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
A2013	Innovamatrix fs per sq cm	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		3/31/2023	Retire effective 03/31/2023
		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	4/4/2022	-,-,-	
A2015	Phoenix wnd mtrx per sq cm	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	4/1/2023	-	Add effective 04/01/2023
A2015	Phoenix wnd mtrx per sq cm	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	_	3/31/2023	Retire effective 03/31/2023
A2017	Permeaderm glove each	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	4/1/2023		Add effective 04/01/2023
	-	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	1/1/2025	-	
A2017	Permeaderm glove each	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 cird 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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	_	-
A4238	Adju Cgm Supply Allowance	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
A4335 A4421	Octomy supply misc	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	-	_	_
A4453	Ostomy supply misc	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
	Rec cath man pump enema repl	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
A4458 A4520	Reusable enema bag Incontinence garment anytype	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	-	-
A4553		Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	_	-
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
A4555	Ca tx e-stim electr/transduc	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. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	_	-
	Replacement Batteries Medically				
A4630		Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	-	-

Manuscript   Manuscript   Manuscript   Manuscript   Control Product   Manuscript   Control Product   Manuscript   Manusc		Replacement Battery For Patient-	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a				
Manual Content   Manu	A4638		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-	
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March   Marc	A4641	Radiopharm dx agent noc		_	_	_	
March   Marc	A4649					_	
Mathematical   Math	A4660	Apparatus With Cuff And		_	_	-	
Mathematical   Math	A4663		Non Covered: Procedure/service not covered by BCRSOK. Not subject to utilization review				
March   Service   American   Service   Servi						_	
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Note   Section	A5507						
Mate	A6000	Wound warming wound cover		-	_	-	
	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.	_	_	_	
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March   1907	A6549	G compression stocking	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	-	_	
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Any Leegin Earn  Any Leegin Earn  EU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Pease see the Clinical Payment and Coding Policy titled: Non- Reimbursable Experimental, investigational and/or Unprovem Services (EU).  EU: Procedure/service procedure/service not subject to utilization review. Pease see the Clinical Payment and Coding Policy titled: Non- Reimbursable Experimental, investigational and/or Unprovem Services (EU).  EU: Procedure/service not subject to utilization review.  Choline C-11. Diagnostic Per Study Dose Up To 20 Millicuries Recommended Clinical Review (Predetermination) request If it is undear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request If it is undear if the service meets BCBSOK (Medical Policy criteria.  Sodium Fluoride F-18 Diagnostic Per Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria.  Sodium Fluoride F-18 Diagnostic Per Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria.  Sodium Fluoride F-18 Diagnostic Per Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria.  Sodium Fluoride F-18 Diagnostic Per Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria.  Sodium Fluoride F-18 Diagnostic Per Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria.  Sodium Fluoride F-18 Diagnostic Per Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria.  Sodium Fluoride F-18 Diagnostic Per Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria.  Sodium Fluoride F-18 Diagnostic Per Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medica	ΛΩ291						
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Sodium Fluoride F-18 Diagnostic Per Study Dose Up To 30 Millicuries Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  A9582 Per Study Dose Up To 15 Millicuries Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  A9588 Fluciciowine F-18 Diagnostic 1 Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria.  A9588 Fluciciowine F-18 Diagnostic 1 Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria.  A9588 Fluciciowine F-18 Diagnostic 1 Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria.  A9586 Gallium Illucck 1 Millicurie Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria.  A9597 Pet dx for rumor id noc Unlisted or Undefined: Procedure/service rot otherwise defined or classified, and may be subject to benefit and/or clinical review.  A9601 Flortaucipir Inj 1 Millicuri  A9602 Fluoradapa F-18 diag per mci Medical Policy Criteria: Procedure/service rot otherwise defined or classified, and may be subject to benefit and/or clinical review.  A9603 Fluoradapa F-18 diag per mci Medical Policy Criteria: Procedure/service rot otherwise defined or classified, and may be subject to benefit and/or clinical review.  A9604 Fluoradapa F-18 diag per mci Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria.  A9605 Fluoradapa F-18 diag per mci Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria.  A9606 Sallium locametz 1 millicuri  A9607 Medical Policy Criteria: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.  A9608 Non-rad contrast materialNOC Unlisted or Undefined: Procedure/		Dose Up To 20 Millicuries	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-	
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	04104	Additive for enteral formula	non covered. Procedure/service not covered by bobbon. 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			
B4149		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
B4149	EF blenderized foods  EF complet w/intact nutrient	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.			-
B4150	EF calorie dense>/=1.5Kcal	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  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 =	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
B4154	1 Unit  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 Enteral Formula Nutritionally		-	-	-
B4157	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
B4158	EF ped complete intact nut	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. Procedure/service reviewed to ensure ach service meets BCBSOK Medical Policy criteria. PCBSOK recommends submitting a	-	-	-
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 MI = 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.	-	_	-
B4172	Homemix 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 MI = 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 MI = 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 MI=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.	-	-	_

	Parenteral Nutrition Supply Kit;	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
B4222	Home Mix Per Day	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.	_	_	_
	Parenteral Nutrition Solution				
	Compounded Amino Acid And Carbohydrates With Electrolytes				
B5000	Trace Elements And Vitamins	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
	Including Preparation Any Strength Renal-Aminosyn-Rf Nephramine				
	Renamine-Premix Parenteral Nutrition Solution				
	Compounded Amino Acid And				
B5100	Carbohydrates With Electrolytes Trace Elements And Vitamins	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
	Including Preparation Any Strength	necommended clinical neview (Fredetermination) request in it is uniced in the service meets busson wedical Policy Citicala.			
	Hepatic Hepatamine-Premix Parenteral Nutrition Solution				
	Compounded Amino Acid And				
B5200	Carbohydrates With Electrolytes Trace Elements And Vitamins	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy Criteria. BCBSOK recommends submitting a			
	Including Preparation Any Strength	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	-
	Stress-Branch Chain Amino Acids- Freamine-Hbc-Premix				
B9004	Parenteral Nutrition Infusion Pump	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_	_	_
00000	Portable Parenteral Nutrition Infusion Pump	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
B9006	Stationary	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.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
C1052	Hemostatic agent gi topic	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	-	-	-
C1062	Intravertebral body fracture augmentation with implant (e.g.,	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_	_	_
	metal, polymer)	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Precedure (service reviewed to accura pack copies meets BCBSOK Medical Policy criteria). PCBSOK recommends submitting a			
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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	_	-
C1767	Generator neuro non-recharg	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	_		_
04700		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
C1783	Ocular imp aqueous drain de	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
C1787	Patient Progr Neurostim	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	_	_
C1818	Integrated keratoprosthesis	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
C1820	Generator Neurostimulator (Implantable) With Rechargeable	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_	_	_
	Battery And Charging System Interspinous Process Distraction	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
C1821	Device (Implantable)	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	_	-
C1831	Personalized Interbody Cage	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	_	_	_
C1883	Adapt/Ext Pacing/Neuro Lead	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK 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 Probe Percutaneous Lumbar	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
C2614	Discectomy	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	_	_	_
C2624		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
C2624	Wireless pressure sensor	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
C2698 C2699	Brachytx stranded NOS  Brachytx non-stranded NOS	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.  Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	-	-	-
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	4/1/2022	-	Add offertive 04/04/2022
C5271	Low cost skin substitute app	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	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. BLBSOK 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	4/1/2023		Add effective 04/01/2023
	**	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a		-	
C5275	Low cost skin substitute app	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	4/1/2023	_	Add effective 04/01/2023
C5277	Low cost skin substitute app		4/1/2023	-	Add effective 04

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	Downstrumeh injection	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
C9257	Bevacizumab injection	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).	-	-	-
29360	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-			
9364	Porcine implant Permacol	Reimbursable Experimental, Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			
29399	unclassified drugs or biologicals	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Unlisted Procedure; May require Prior Authorization per contract agreement.	-	-	-
9734	U/S trtmt not leiomyomata	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	_	
9739		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a		_	
	Cystoscopy prostatic imp 1-3	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	_
9740	Cysto impl 4 or more	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
9757	Spine/lumbar disk surgery	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	-	-	-
9764	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.	-	-	_
9765	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.	_	_	-
9766	Revasc intra lithotrip-ather	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_	_	_
9767	Revasc lithotrip-stent-ather	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	=		
		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
29768	Endo us-guide hep porto grad	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
29769	Cysto w/temp pros implant	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
29770	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.	-	-	-
09771	NsI/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).	_	_	_
9772	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-	_	_	_
9773	Revasc lithotr-stent tib/per	Reimbursable Experimental, Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			
	<u> </u>	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-		_	-
29774	Revasc lithotr-ather tib/per	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
29775	Revasc lith-sten-ath tib/per	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	-	-	-
29777	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).	-	-	-
29780	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.	_	_	_
29899	Inpt implant pros dev no cov unspecified diagnostic procedure by	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
00999	report	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	-	-	-
01705	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.	_	_	-
01999	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.	-	_	-
02999	unspecified restorative procedure by	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.		_	_
03999	report unspecified endodontic procedure	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.			
04999	by report unspecified periodontal procedure	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	-	-	-
	by report unspecified removable prosthodontic		-	-	-
D5899	procedure by report unspecified maxillofacial prosthesis	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	-	-	-
D5999	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	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.		_	_
D8999	by report unspecified orthodontic procedure	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	-	_	-
D9999	by report unspecified adjunctive procedure by	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	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets RCRSOK Medical Policy Criteria. RCRSOK recommends submitting a	-	_	-
0182	Includes Heavy Duty Pump For Alternating Pressure Pad	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy Criteria. BCBSOK recommends submitting a			
	For Replacement Only	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	_
0183	Press underlay alter w/pump	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	_
0184	Dry Pressure Mattress	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.		-	<u>-</u>
0186	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.	_	_	
		ncommended cannot neview (Frederentination) request it it is undeat it the service meets bubbok 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	_	_	_
E0190	Positioning cushion	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.			_
	Powered Air Flotation Bed (Low Air	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
E0193	Loss Therapy)	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			
20130	GCTT C33dTC Width C33	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.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			_
E0221	Infrared heating pad system	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.	_	_	_
50004		EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			
E0231	Wound warming device	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			
EU230	Pump for water circulating p	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.			-
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_	-	-
E0249	Pad water circulating heat u	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.	_	_	-
	Hospital Bed Variable Height Hi-Lo	, ,			
E0255	With Any Type Side Rails With	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_	_	_
	Mattress	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	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
20230	Mattress	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	-	-
	Hospital Bed Semi-Electric (Head				
F0260		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy Criteria. BCBSOK recommends submitting a			
E0260	And Foot Adjustment) With 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.	-	-	-
E0260		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
E0260 E0261	And Foot Adjustment) With Any Type Side Rails With Mattress Hospital Bed Semi-Electric (Head And Foot Adjustment) With Any	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
	And Foot Adjustment) With Any Type Side Rails With Mattress Hospital Bed Semi-Electric (Head And Foot Adjustment) With Any Type Side Rails Without Mattress	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
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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	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy Criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy Criteria.	_	_	-
	To 600 Pounds With Any Type Side Rails Without Mattress Hospital Bed Extra Heavy Duty Extra				
E0302	Wide With Weight Capacity Greater Than 600 Pounds With Any Type Side Rails Without Mattress	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		-	-	-
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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	_
E0471	RAD w/backup non inv intrfc  Intrapulmonary Percussive	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	_
E0481	Ventilation System And Related Accessories Cough Stimulating Device	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
E0482	Alternating Positive And Negative Airway Pressure High Frequency Chest Wall	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK 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	Oscillation System Includes All Accessories And Supplies Each Oscillatory Positive Expiratory	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK 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	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 Seat Lift Mechanism Non Electric	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK 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		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK 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	Position (E.G. Three-Way Stander) Any Size Including Pediatric With Or	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
	Without Wheels				

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			_
E0657	Segmental pneumatic chest	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			_
E0660	Pneumatic appliance full leg	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			-
		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
E0665	Pneumatic appliance full arm	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
E0666	Pneumatic appliance half leg	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	_	_	_
E0672	Pressure pneum appl full arm	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
E0673	Pressure pneum appl half leg	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			_
		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
E0675	Pneumatic compression device	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
E0676	Inter limb compress dev NOS	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	_	_	_
E0705	Transfer Device Any Type Each	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  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	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.		-	-
E0731	Stimulation Form Fitting Conductive Garment For Delivery Of Tens Or Nmes (With Conductive Fibers Separated From	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
	The Patient'S Skin By Layers Of Fabric)	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			_
E0740	Non-implant pelv flr e-stim	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	_	_	_
E0761	Nontherm electromgntc device	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			_
E0762	Trans elec jt stim dev sys	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	=	<u> </u>	
E0764	Functional neuromuscularstim	Reimbursable Experimental, Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	_	_	-
E0766	Elec stim cancer treatment	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	=	-
		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-		-	-
E0769	Electric wound treatment dev	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	-	-	-
E0770 E0781	External ambulatory infus pu	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
20/01	Infusion Pump Implantable Non-	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
E0782	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	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK 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.	-	-	-

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Company   Comp	E0830	Ambulatory traction device		-	-	_
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melinate from the control of the con	E0856	Cervic collar w air bladders	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	-	-	-
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selection of the select	E0942	Cervical head harness/halter	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	-	-	-
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Section of the Contraction of th	E0946	Fracture frame dual w cross		_	_	-
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Second provided in the commendation of the com	F0981	Seat unholstery replacement	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
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And priviled   Recommended Clinical Review Predefermantation   request if it is unclear if the service meets DCGSON Medical Policy criteria.   -   -   -   -	E0983	Add pwr joystick	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.		-	-
Recommended Clinical Review Predetermination   Recommended Clinical Review Predetermination   request if it is unclear if the service meets \$10,500 Medical Policy criteria. SeaSOM Recommended Standard   Recommended Clinical Review Predetermination   request if it is unclear if the service meets \$2,500 Medical Policy criteria. SEGOM Recommended Clinical Review Predetermination   request if it is unclear if the service meets \$2,500 Medical Policy criteria. SEGOM recommends submitting a	E0984	Add pwr tiller		-	-	-
Many w/c push-imp pour system Many w	E0985	W/c seat lift mechanism		_	_	_
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Weight Capacity Greater Than 300 Recommended Linical Keview (Predetermination) request in it is unclear in the service meets BLBSUK Medical Policy Criteria.	E1026	System Extra-Wide With Integrated	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
Lbs	C103p	Weight Capacity Greater Than 300	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
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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	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	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK 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	Footrest  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	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK 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	Swing Away Detachable Footrest High Strength Lightweight Wheelchair Detachable Arms Desk Or Full Length Swing Away	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK 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	Detachable Foot Rests 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	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK 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.  Medical Policy Criteria: Procedure/conject graphing to the procedure of the	-	-	-
E1170	Whichr 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. Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
E1171	Wheelchair amputee w/o leg r	Medical Policy Citteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy citeria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
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. Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
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	_	_	_
E1226	Manual fully reclining back	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_	_	_
	, 0	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	_

		Madical Daliar Critaria, Procedura (consign reviewed to ensure each consign mosts DCDCOV Madical Daliar critaria, DCDCOV recommends submitting a			
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.		-	-
1228	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.	-	_	_
1229	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
E1230	Power operated vehicle	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
1231	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	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
L1232	Seating System	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	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
	Seating System Wheelchair Pediatric Size Rigid	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
1235	Adjustable With Seating System	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
1236	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.	-	-	-
1237	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	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
	Adjustable Without Seating System	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	_
E1239	Ped power wheelchair NOS	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	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
	And/Or Width By Construction	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-		-
E1300 E1310	Whirlpool portable Whirlpool non-portable	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  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.	_	_	
1629	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.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			<del>-</del>
E1632	Wearable artificial kidney	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.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	_
E1700	Jaw motion rehab system	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).	_	_	_
1702	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-			
	Dynamic Adjustable Elbow	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	-	-	-
1800	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.	-	-	-
1805	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	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK 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	And Accessories  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. 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		_	_
E2211	Pneumatic propulsion tire	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_	_	_
E2212	Pneumatic prop tire tube	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
E2213	Pneumatic prop tire insert	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			-
E2214	Pneumatic caster tire each	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			-
E2215	Pneumatic caster tire tube	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a		-	-
E2216		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_		-
E2216	Foam filled propulsion tire  Foam filled caster tire each	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
E2218 E2219	Foam propulsion tire each  Foam caster tire any size ea	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
E2219	•	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
	Solid propuls tire repl ea	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
E2221	Solid caster tire repl each	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
E2222	Solid caster integ whl repl	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
E2228	Mwc acc wheelchair brake	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
E2230	Manual standing system	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
E2231	Solid seat support base	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
E2291	Planar back for ped size wc	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
E2292	Planar seat for ped size wc	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	_

		Moderal Bellin Citizate Boundary (and an advantage of the property of the prop			
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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
E2300	Pwr seat elevation sys	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			-
E2312	Mini-prop remote joystick	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	_	-
E2313	PWC harness expand control	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			-
E2324	Chin cup interface	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
E2325	Sip and puff interface	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	_	_	_
E2328	Head/extremity control inter	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
	ricady extremity control litter	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-		-
E2329	Head control nonproportional	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
E2341	W/c wdth 24-27 in seat frame	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	_		
	POWER WHEELCHAIR ACCESSORY	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			_
E2358	GROUP 34 NON-SEALED LEAD ACID BATTERY EACH	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
	POWER WHEELCHAIR ACCESSORY				
E2359	GROUP 34 SEALED LEAD ACID BATTERY EACH (E.G. GEL 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.	-	-	-
	ABSORBED GLASSMAT)				
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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
E2363	Gr24 sealed leadacid battery	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
E2364	U1nonsealed leadacid battery	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	_	_	_
E2367	Battery charger dual mode	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
E2371	Gr27 sealed leadacid battery	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
E2375	Non-expandable controller	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
E2376	Expandable controller repl	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	_	_	_
E2402	Neg press wound therapy pump	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_		-
E2500	SGD digitized pre-rec <=8min	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	_	_	_
E2508	SGD spelling phys contact	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			=
L2300	See spennig priys contdet	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	_

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WHEELCHAIR ACCESSORY ADDITION E2631 TO MOBILE ARM 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.	
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Services Performed By A Qualified  Physical Therapist 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.  Minutes	

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		-	-	-
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-	_	_	_
G0276	Pild/placebo control clin tr	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  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).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			_
G0282	Elect stim wound care not pd  Electrical Stimulation (Unattended)	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	-	-	-
G0283	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.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	_	-
G0295	Pre-Operative Pulmonary Surgery	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	-	-	-
G0302	Services For Preparation For Lyrs 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	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK 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	To 15 Days Of Services Pre-Operative Pulmonary Surgery Services For Preparation For Lvrs 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.	-	-	-
G0305	To 9 Days Of Services 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 G0315	Counsel immune <21 16-30 m  Counsel immune <21 5-15 m	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  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					
00330	Facility svs dental rehab	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G0333	Facility svs dental rehab  Pharmacy Dispensing Fee For Inhalation Drug(S); Initial 30-Day Supply As A Beneficiary	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-

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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a				
G0343	Laparotomy islet cell transp	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-	
	Physician Service Required To					
C0272	Establish And Document The Need	New Countries Decordure (continue and resulted by DCDCOV). Net subject to utilization socials				
G0372	For A Power Mobility Device (Use In Addition To Primary Evaluation And	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	-	-	
	Management Code)					
	Intensive Cardiac Rehabilitation;					
G0422	With Or Without Continuous Ecg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a				
	Monitoring With Exercise Per	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	_	
	Session Intensive Cardiac Rehabilitation;					
	With Or Without Continuous Ecg	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a				
G0423	Monitoring; Without Exercise Per	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-	
	Session					
	Collagen Meniscus Implant	FILL Decoder for the state of the DCFCOV Net subject to still state of the DCFCOV Net subject to state of the DCFCOV				
G0428	(e.g. CMI collagen scaffold	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_	
	Menaflex)	neimbursable Experimental, investigational and/or oriproven services (Eto).				
	Dermal Filler injection(s) for the					
G0429	treatment of facial lipodystrophy	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a				
00423	syndrome (LDS) (e.g. as a result of	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-	
	highly active antiretroviral therapy.) Insertion Or Replacement Of A					
	Permanent Pacing Cardioverter-					
	Defibrillator System With					
G0448	Transvenous Lead(S) Single Or Dual	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_	_	_	
	Chamber With Insertion Of Pacing	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.				
	Electrode Cardiac Venous System					
	For Left Ventricular Pacing	Malia Della Citata Danda de la constanta de la				
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.	-	_	_	
		EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-				
G0460	Autolog prp not diab ulcer	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-				
30.00		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.	_	_	_	
	Removal Of Non-Biodegradable Drug					
G0517	Delivery Implants 4 Or More	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy Criteria. BCBSOK recommends submitting a				
	(Services For Subdermal Implants)	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				
00318		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-	
	Alcohol And/Or Substance (Other					
G2011	Than Tobacco) Misuse Structured	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	
	Assessment (E.G. Audit Dast) And Brief Intervention 5-14 Minutes					
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a				
G2082	Visit esketamine 56m or less	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 30 mins  Chronic pain mgmt addl 15m	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	_		
			- - -	<u>-</u> -		
G3003	Chronic pain mgmt addl 15m	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	- -		-	
G3003 G8395 G8396	Chronic pain mgmt addl 15m LVEF>=40% doc normal or mild LVEF not performed	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	- - -	- - -	- - -	
G3003 G8395 G8396 G8397	Chronic pain mgmt addl 15m  LVEF>=40% doc normal or mild  LVEF not performed  Dil macula/fundus exam/w doc	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	- - - -	- - - -	- - -	
G3003 G8395 G8396 G8397 G8399	Chronic pain mgmt addl 15m LVEF>=40% doc normal or mild LVEF not performed Dil macula/fundus exam/w doc Pt w/dxa results document	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	- - - -	- - - -	- - - -	
G3003 G8395 G8396 G8397 G8399 G8400	Chronic pain mgmt addl 15m  LVEF>=40% doc normal or mild  LVEF not performed  Dil macula/fundus exam/w doc  Pt w/dxa results document  Pt w/dxa no results doc	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	- - - - -	- - - - - -	- - - - -	
G3003 G8395 G8396 G8397 G8399	Chronic pain mgmt addl 15m LVEF>=40% doc normal or mild LVEF not performed Dil macula/fundus exam/w doc Pt w/dxa results document	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	-	- - - - -	
G3003 G8395 G8396 G8397 G8399 G8400	Chronic pain mgmt addl 15m  LVEF>=40% doc normal or mild  LVEF not performed  Dil macula/fundus exam/w doc  Pt w/dxa results document  Pt w/dxa no results doc	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	-		
G3003 G8395 G8396 G8397 G8399 G8400 G8404	Chronic pain mgmt addl 15m  LVEF>=40% doc normal or mild  LVEF not performed  Dil macula/fundus exam/w doc  Pt w/dxa results document  Pt w/dxa no results doc  Low extemity neur exam docum	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	-		
G3003 G8395 G8396 G8397 G8399 G8400 G8404 G8405	Chronic pain mgmt addl 15m  LVEF>=40% doc normal or mild  LVEF not performed  Dil macula/fundus exam/w doc  Pt w/dxa results document  Pt w/dxa no results doc  Low extemity neur exam docum  Low extemity neur not perfor	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	- - - - - -	-	-	
G3003 G8395 G8396 G8397 G8399 G8400 G8404 G8405 G8415	Chronic pain mgmt addl 15m  LVEF>=40% doc normal or mild  LVEF not performed  Dil macula/fundus exam/w doc  Pt w/dxa results document  Pt w/dxa no results doc  Low extemity neur exam docum  Low extemity neur not perfor  Eval on foot documented  Eval on foot not performed	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	-	-	
G3003 G8395 G8396 G8397 G8399 G8400 G8404 G8405 G8415 G8416	Chronic pain mgmt addl 15m  LVEF>=40% doc normal or mild  LVEF not performed  Dil macula/fundus exam/w doc  Pt w/dxa results document  Pt w/dxa no results doc  Low extemity neur exam docum  Low extemity neur not perfor  Eval on foot documented  Eval on foot not performed  Pt inelig footwear evaluatio	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-		-	
G3003 G8395 G8396 G8397 G8399 G8400 G8404 G8405 G8415 G8416 G8417	Chronic pain mgmt addl 15m  LVEF>=40% doc normal or mild  LVEF not performed  Dil macula/fundus exam/w doc  Pt w/dxa results document  Pt w/dxa no results doc  Low extemity neur exam docum  Low extemity neur not perfor  Eval on foot documented  Eval on foot not performed  Pt inelig footwear evaluatio  Calc bmi abv up param f/u	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	-	-	
G3003 G8395 G8396 G8397 G8399 G8400 G8404 G8405 G8415 G8416	Chronic pain mgmt addl 15m  LVEF>=40% doc normal or mild  LVEF not performed  Dil macula/fundus exam/w doc  Pt w/dxa results document  Pt w/dxa no results doc  Low extemity neur exam docum  Low extemity neur not perfor  Eval on foot documented  Eval on foot not performed  Pt inelig footwear evaluatio	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-		-	
G3003 G8395 G8396 G8397 G8399 G8400 G8404 G8405 G8415 G8416 G8417	Chronic pain mgmt addl 15m  LVEF>=40% doc normal or mild  LVEF not performed  Dil macula/fundus exam/w doc  Pt w/dxa results document  Pt w/dxa no results doc  Low extemity neur exam docum  Low extemity neur not perfor  Eval on foot documented  Eval on foot not performed  Pt inelig footwear evaluatio  Calc bmi abv up param f/u	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-		-	
G3003 G8395 G8396 G8397 G8399 G8400 G8405 G8410 G8415 G8416 G8417 G8418	Chronic pain mgmt addl 15m  LVEF>=40% doc normal or mild  LVEF not performed  Dil macula/fundus exam/w doc  Pt w/dxa results document  Pt w/dxa no results doc  Low extemity neur exam docum  Low extemity neur not perfor  Eval on foot documented  Eval on foot not performed  Pt inelig footwear evaluatio  Calc bmi abv up param f/u  Calc bmi blw low param f/u	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-		-	
G3003 G8395 G8396 G8397 G8399 G8400 G8404 G8405 G8410 G8415 G8416 G8417 G8418 G8419 G8420	Chronic pain mgmt addl 15m  LVEF>=40% doc normal or mild  LVEF not performed  Dil macula/fundus exam/w doc  Pt w/dxa results document  Pt w/dxa no results doc  Low extemity neur exam docum  Low extemity neur exam docum  Eval on foot documented  Eval on foot not performed  Pt inelig footwear evaluatio  Calc bmi abv up param f/u  Calc bmi out nrm param nof/u  Calc bmi out nrm param nof/u  Calc bmi norm parameters	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-			
G3003 G8395 G8396 G8397 G8399 G8400 G8404 G8405 G8410 G8415 G8416 G8417 G8418 G8419 G8420 G8421	Chronic pain mgmt addl 15m  LVEF>=40% doc normal or mild  LVEF not performed  Dil macula/fundus exam/w doc  Pt w/dxa results document  Pt w/dxa no results doc  Low extemity neur exam docum  Low extemity neur not perfor  Eval on foot documented  Eval on foot not performed  Pt inelig footwear evaluatio  Calc bmi abv up param f/u  Calc bmi out nrm param nof/u  Calc bmi norm parameters  Bmi not calculated	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.				
G3003 G8395 G8396 G8397 G8399 G8400 G8404 G8405 G8410 G8415 G8416 G8417 G8418 G8419 G8420 G8421 G8427	Chronic pain mgmt addl 15m  LVEF>=40% doc normal or mild  LVEF not performed  Dil macula/fundus exam/w doc  Pt w/dxa results document  Pt w/dxa no results doc  Low extemity neur exam docum  Low extemity neur not perfor  Eval on foot documented  Eval on foot not performed  Pt inelig footwear evaluatio  Calc bmi abv up param f/u  Calc bmi out nrm param nof/u  Calc bmi norm parameters  Bmi not calculated  Docrev cur meds by elig clin	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.				
G3003 G8395 G8396 G8397 G8400 G8404 G8405 G8410 G8416 G8416 G8417 G8418 G8419 G8420 G8421 G8427 G8428	Chronic pain mgmt addl 15m  LVEF>=40% doc normal or mild  LVEF not performed  Dil macula/fundus exam/w doc  Pt w/dxa results document  Pt w/dxa no results doc  Low extemity neur exam docum  Low extemity neur not perfor  Eval on foot documented  Eval on foot not performed  Pt inelig footwear evaluatio  Calc bmi abv up param f/u  Calc bmi out nrm param nof/u  Calc bmi norm parameters  Bmi not calculated  Docrev cur meds by elig clin  Cur meds not document	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.				
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G3003 G8395 G8396 G8397 G8399 G8400 G8404 G8405 G8410 G8415 G8416 G8417 G8418 G8419 G8420 G8421 G8427 G8428 G8430 G8431 G8432 G8430 G8431 G8432 G8436 G8451 G8456 G8473 G8476 G8477	Chronic pain mgmt addl 15m  LVEF>=40% doc normal or mild  LVEF not performed  Dil macula/fundus exam/w doc  Pt w/dxa results document  Pt w/dxa no results doc  Low extemity neur exam docum  Low extemity neur not perfor  Eval on foot documented  Eval on foot not performed  Pt inelig footwear evaluatio  Calc bmi abv up param f/u  Calc bmi abv up param f/u  Calc bmi out nrm param nof/u  Calc bmi out nrm param nof/u  Calc bmi out nrm param eters  Bmi not calculated  Docrev cur meds by elig clin  Cur meds not document  Doc med rsn no medrec  Pos clin depres scrn f/u doc  Dep scr not doc rng  Scr for dep not cpt doc rsn  Beta-bloc rx pt w/abn lvef  Pt w/abn lvef inelig b-bloc  Pt w/abn lvef b-bloc no rx  High risk recurrence pro ca  ACE/ARB thxpy rx?d  Ace/arb not rx'd; doc reas  ACE/ARB thxpy not rx?d  Bp sys >=140 and/or dias >=90  Bp sys>=140 and/or dias >=90	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject				

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		Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.			_
	Oncology tx decision-mgmt			-	_
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		Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.			
	Onc dx nsclc stgl no progres			_	-
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		Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.			
	Onc dx colon T4 N0 w/o prog				_
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		Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.			
	One dx esophageal T4 no prog		-	-	-
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.			
			-	-	-

	Oncology; Disease Status; Limited To Multiple Myeloma Systemic Disease;				
G9128	Smoldering Stage I (For Use In A	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
	Medicare-Approved Demonstration Project)				
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.	_	_	_
	Outpatient Intravenous Insulin				
	Treatment (OIVIT) either pulsatile or				
	continuous by any means guided by the results of measurements	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			
G9147	for:respiratory quotient; and/or	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	-	-	-
	urine urea nitrogen (UUN); and/or				
	arterial venous or capillary glucose; and/or potassium concentration				
H0031	Mental Health Assessment By Non-	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.			
	Physician  Mental Health Service Plan		-	-	_
H0032	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	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
H0041	Program Per Diem Foster Care Child Non-Therapeutic	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.			
	Per Diem Foster Care Child Non-Therapeutic		_	-	-
H0042	Per Month	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	-	-
H0043	Supported Housing Per Diem Supported Housing Per Month	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	-	-
	Respite Care Services Not In The				
H0045	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  Non-Medical Family Planning	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.			_
H1010	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	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.			
	State Defined Purposes Comprehensive Multidisciplinary				
H2000	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	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	
H2014	Diem Skills Training And Development Per	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.			
H2015	15 Minutes Comprehensive Community Support	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.			
	Services Per 15 Minutes Comprehensive Community Support		-	-	-
H2016	Services Per Diem Community-Based Wrap-Around	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	-	-
H2021	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	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.			
H2024	Minutes Supported Employment Per Diem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.			
H2025	Ongoing Support To Maintain	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.			
	Employment Per 15 Minutes Ongoing Support To Maintain		-	-	-
H2026	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	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.			
H2030	Per Diem  Mental Health Clubhouse Services	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-		-
	Per 15 Minutes Mental Health Clubhouse Services		-	-	-
H2031	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	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	-	_
	Per 15 Minutes	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
J0129	Abatacept injection	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.	_	_	_
10190	Agalaidasa heta iniastica	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
J0180	Agalsidase beta injection	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.			
30202	injection dicintazamas	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.	_	_	_
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
J0219	Inj aval alfa-nqpt 4mg	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
J0220	Alglucosidase alfa injection	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
J0221	INJECTION ALGLUCOSIDASE 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.			
	(LUMIZYME) 10 MG	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.			
30223	ing givesiran e.s mg	Prior Authorization may be required per contract agreement.	-	-	-
10224	Ini lumosisan O.E.ma	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
J0224	Inj. lumasiran 0.5 mg	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	1/1/2023	_	Add effective 01/01/2023
J0256	Alpha 1 proteinase inhibitor	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.			
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	_	-
J0270	Alprostadil for injection	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			
30770	, Jecon Saliercapior Fel 100 Mg	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	_	-
J0490	INJECTION BELIMUMAB 10 MG	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.			
30.131	injulini olanida inid zing	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.			
30317	inj. bemanzamab 1 mg	Prior Authorization may be required per contract agreement.	-	-	-
IOFEE	Ini harlatayumah 10 ma	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
J0565	Inj bezlotoxumab 10 mg	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.	-	-	-
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
J0567	Inj. cerliponase alfa 1 mg	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.	-	-	-
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
J0584	Injection burosumab-twza 1m	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.	-	-	-
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
J0585	Injection onabotulinumtoxinA	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
J0586	AbobotulinumtoxinA	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
J0587	Inj rimabotulinumtoxinB	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
J0588	INJECTION INCOBOTULINUMTOXIN A 1 UNIT	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
	N 20111	Prior Authorization may be required per contract agreement.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
J0598	C-1 esterase cinryze	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.  Modies   Delice Citation Procedure/conice reviewed to ensure each conice most DCDCOV Modies   Delice criteria   DCDCOV recommends submitting a			
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.	-	-	-
10630	Canakinumah injertir	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
J0638	Canakinumab injection	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.	-	-	-
107.17		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
J0717	Certolizumab pegol inj 1mg	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.	-	-	-
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
J0775	Collagenase clost hist inj	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.	-	-	-
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
J0791	Inj crizanlizumab-tmca 5mg	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
J0881	Darbepoetin alfa non-esrd	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy Criteria. BCBSOK recommends submitting a			
J0888	Epoetin beta non esrd	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	_	_
	Injection Deferoxamine Mesylate	Prior Authorization may be required per contract agreement.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
J0895	500 Mg	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.	_	_	_
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
J1290	Ecallantide injection	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy Criteria. BCBSOK recommends submitting a			
J1300	Eculizumab injection	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
J1301	Injection edaravone 1 mg	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
J1302	Inj sutimlimab-jome 10 mg	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	_
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14202	let exactlement and 10 era	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a				
J1303	Inj. ravulizumab-cwvz 10 mg	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.	-	-	-	
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a				
J1305	Inj evinacumab-dgnb 5mg	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.	-	-	-	
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a				
J1306	Injection inclisiran 1 mg	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a				
J1322	Elosulfase alfa injection	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.				
	<u> </u>	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				
11323	Epoprosterior injection	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				
31120	injection casimersen 10 ing	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.	-	-	_	
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a				
J1428	Inj eteplirsen 10 mg	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.	-	-	-	
14.420	IniI-di 10	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a				
J1429	Inj golodirsen 10 mg	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.				
31130	Gaisanase injection	Prior Authorization may be required per contract agreement.	-	-	-	
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a				
J1551	Inj cutaquig 100 mg	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.	-	-	-	
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a				
J1554	Inj. asceniv	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a				
J1562	Vivaglobin inj	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	lvig non-lyophilized NOS	Unlisted Procedure; May require Prior Authorization per contract agreement.	_	_	_	
14.602	Callianumah familianum Ama	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a				
J1602	Golimumab for iv use 1mg	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	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a				
31020	Per 100 Mcg	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.	-	-	_	
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a				
J1675	Histrelin acetate	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a				
J1726	Makena 10 mg					
31720	Makena 10 mg	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_	
31720	Wakena 10 mg	Prior Authorization may be required per contract agreement.	-	-	-	
J1729	Inj hydroxyprogst capoat nos		-	-	-	
J1729	Inj hydroxyprogst capoat nos	Prior Authorization may be required per contract agreement.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-	
		Prior Authorization may be required per contract agreement.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	- -	- -	
J1729	Inj hydroxyprogst capoat nos	Prior Authorization may be required per contract agreement.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	- - -	- - -	- -	
J1729	Inj hydroxyprogst capoat nos	Prior Authorization may be required per contract agreement.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK 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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	- - -	- - -	-	
J1729 J1743	Inj hydroxyprogst capoat nos Idursulfase injection	Prior Authorization may be required per contract agreement.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK 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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK 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 J1743	Inj hydroxyprogst capoat nos Idursulfase injection	Prior Authorization may be required per contract agreement.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK 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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	- - -	-	
J1729 J1743 J1745	Inj hydroxyprogst capoat nos Idursulfase injection Infliximab not biosimil 10mg	Prior Authorization may be required per contract agreement.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	- - -	- - -	- - -	
J1729 J1743 J1745 J1746	Inj hydroxyprogst capoat nos  Idursulfase injection  Infliximab not biosimil 10mg  Inj. ibalizumab-uiyk 10 mg	Prior Authorization may be required per contract agreement.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Prior Authorization may be required per contract agreement.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Prior Authorization may be required per contract agreement.	- - -	- - -	- - -	
J1729 J1743 J1745	Inj hydroxyprogst capoat nos Idursulfase injection Infliximab not biosimil 10mg	Prior Authorization may be required per contract agreement.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	- - - -	- - - -	- - - -	
J1729 J1743 J1745 J1746 J1786	Inj hydroxyprogst capoat nos  Idursulfase injection  Infliximab not biosimil 10mg  Inj. ibalizumab-ulyk 10 mg  Imuglucerase injection	Prior Authorization may be required per contract agreement.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended	- - - -	- - - -	- - - -	
J1729 J1743 J1745 J1746	Inj hydroxyprogst capoat nos  Idursulfase injection  Infliximab not biosimil 10mg  Inj. ibalizumab-uiyk 10 mg	Prior Authorization may be required per contract agreement.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	- - - - -	- - - -	- - - -	
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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	Ini posicontido 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.			
12302	Inj pasireotide long acting	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.	_	_	_
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
J2507	INJECTION PEGLOTICASE 1 MG	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			_
J2778	Injection Ranibizumab 0.1 Mg	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-		-
J2779	Inj susvimo 0.1 mg	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
J2787	Riboflavin 5'Phos opth<=3ml	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
J3032	Inj. eptinezumab-jjmr 1 mg	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
J3060	Inj taliglucerace alfa 10 u	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
J3121	Inj testostero enanthate 1mg	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
J3145	Testosterone undecanoate 1mg	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.	-	-	-
122.11	led Assessment of the Control	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
J3241	Inj. teprotumumab-trbw 10 mg	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			
15245	IIIJ. CIIGIAKIZUIIIAD I IIIg	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
J3299	Inj xipere 1 mg	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 lu	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.			
15550	Ostekindinab iv inject 1 mg	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.	_		
	<u> </u>	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
J3396	Verteporfin injection	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
J3398	Inj luxturna 1 billion vec g	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
J3399	Inj onase abepar-xioi treat	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	-
J3490	Drugs unclassified injection	Prior Authorization may be required per contract agreement.  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.  Non Countrie Precedure (region and countrie by PCPSOK, Not cubic to utilization review.	-	-	-
J3570 J3590	Laetrile amygdalin vit B17  Unclassified biologics	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	_	-
J7178	Inj human fibrinogen con nos	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
J7192	Factor viii recombinant NOS	Prior Authorization may be required per contract agreement.  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	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy Criteria. BCBSOK recommends submitting a			
	Dosage Form (354 Mg)	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	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_	_	_
	Gram	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
1		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
J7311	Inj. retisert 0.01 mg	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-		_
J7311 J7312	Inj. retisert 0.01 mg Injection Dexamethasone Intravitreal Implant 0.1 Mg				_

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				
1/316	injection Ocripiasmin 0.125 Mg	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.				
37340	Carbidopa icvodopa circ 100iiii	Prior Authorization may be required per contract agreement.	-	-	-	
J7345	Aminolevulinic Acid Hcl For Topical	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_			
	Administration 10% Gel 10 Mg	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a				
J7351	Inj bimatoprost itc imp1mcg	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	_	_	_	
J7599	Immunosuppressive drug noc	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.				
		EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			_	
J7604	Acetylcysteine comp unit	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).	_	_	_	
17500	40 - 1 - 1	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-				
J7609	Albuterol comp unit	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).	_	_	_	
17645	Lavalla da sal assessible	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-				
J7615	Levalbuterol comp unit	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).	_	_	_	
17624	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-				
J7624	betamethasone comp unit	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-				
37020	Bitoiteroi mesyiate comp con	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).	-	-	-	
17622	Cromolus codium compunit	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-				
J7632	Cromolyn sodium comp unit	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	Atronino como con	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-				
37033	Atropine comp con	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-				
37037	bexamethasone comp con	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-				
37010	Tormoteror comp unit	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-			
J7641	Flunisolide comp unit	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).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-				
J7643	Glycopyrrolate comp unit	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).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-				
J7647	Isoetharine comp con	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).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-				
J7657	Isoproterenol comp con	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).	_	_	_	
		EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-				
J7667	Metaproterenol comp con	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).	_	_	_	
17676	Destauriding community days	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-				
J7676	Pentamidine comp unit dose	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-				
3,001	reroutanine sun comp unit	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-				
37004	amemorate comp unit	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		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_			
1724/	Inj melphalan flufenami 1mg	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.				
35551	ing sironinus proc part 1 mg	Prior Authorization may be required per contract agreement.	-	-	-	

		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy Criteria. BCBSOK recommends submitting a			
J9332	Inj efgartigimod 2mg	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
10500		Prior Authorization may be required per contract agreement.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
J9600		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
19999		Unlisted Procedure; May require Prior Authorization per contract agreement.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	_	-
K0002	Strid hemi (low seat) whichr	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
коооз		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK 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 Itwt whichr	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_		
		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
K0005	Oltralightweight wheelchair	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	_	-
K0006		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK 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		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK 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/hase	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			-
K0009	Other manual wheelchair/base	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
K0010		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK 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		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_	_	_
K0012		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
K0012		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_	_	-
K0013	Custom power which pase	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
K0014		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK 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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
K0056	Seat ht <17 or >=21 ltwt wc	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.			_
K0065		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK 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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-		
K0455		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_	_	-
K0669	Seat/back cus no dmepdac ver	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
K0743		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	-
	ABSORPTIVE WOUND DRESSING FOR				
K0744	MODEL PORTABLE PAD SIZE 16	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
	SQUARE INCHES OR LESS Absorptive Wound Dressing For Use				
	With Suction Pump, Home Model,	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
K0745		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCRSOK Medical Policy criteria.	-	-	-
	To 48 Square Inches				
	ABSORPTIVE WOUND DRESSING FOR	Madical Ballic Cataria, Boundary (and a second as a se			
K0746		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
	GREATER THAN 48 SQUARE INCHES				
K0800		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_	_	_
K0801		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
KU0U1		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-		-
K0802	POV group 1 vhd 451-600 lbs	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
к0806	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			_
K0808	POV group 2 vnd 451-600 lbs	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
K0812		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK 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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
K0814	PWC gp 1 std port cap chair	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	_	-
K0815		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK 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		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK 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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			_
K0821	PWC gp 2 std port cap chair	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 gn 2 std can 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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
K0824	PWC gp 2 nd seat/back	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	_	_
K0825		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	-	
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
K0826		Recommended Clinical Review (Predetermination) request if it is unclear if the consist mosts DCBCOV Madical Ballou existeria	_		
	PWC gp 2 vnd seat/back	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
K0826 K0827 K0828	PWC gp vhd cap chair		-	_	-

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			
K0830	r we gpz stu seat elevate s/ b	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
K0831	PWC gp2 std seat elevate cap	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
K0837	PWC gp 2 hd sing pow opt s/b	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
к0838	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
K0840	PWC gp2 xhd sing pow opt s/b	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
K0848	PWC gp 3 std seat/back	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			_
K0851	PWC gp 3 hd cap chair	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	_	_	_
K0854	PWC gp 3 xhd seat/back	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
KU634	PWC gp 3 xiiu seatyback	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
K0855	PWC gp 3 xhd cap chair	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
к0856	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-		-
K0858	PWC gp3 hd sing pow opt s/b	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
к0859	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	_	_	_
K0861	DMC and and multinous ant all	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
K0001	PWC gp3 std mult pow opt s/b	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
K0862	PWC gp3 hd mult pow opt s/b	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
к0863	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			-
K0868	PWC gp 4 std seat/back	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	_	_	_
K0871	PWC gp 4 vhd seat/back	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
K0871	r we gp 4 viiu seaty back	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
K0877	PWC gp4 std sing pow opt s/b	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
к0878	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			
	<u> </u>	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
K0880	PWC gp4 vhd sing pow opt s/b	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
K0886	PWC gp4 hd mult pow s/b	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
K0890	PWC gp5 ped sing pow opt s/b	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.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-		-
K1002	Ces system	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).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	_	=
K1009	Speech volume modulation sys	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.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	_
K1018	Ext up limb tremor stim wris	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).	-	_	_
		F			

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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
K1022	Endoskel posit rotat unit	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).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			
K1025	Non pneum compress full arm	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	_	_	_
V4.020	One I De / Anna Name and Anna Anna I	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
K1029	Oral Dv/App Neuromus Mouthpi	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-			
KIUSI	Non pried comp control w/o ca	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
K1032	Non pneum seq comp full leg	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).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-		
K1033	Non pneum seq comp half leg	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	_
L1834	Ko w/0 joint rigid molded to	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			
21044	ko w/auj je rot char molacu	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	_
L1846	Ko w adj flex/ext rotat mold	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 L3001	Lower extremity orthosis NOS  Foot insert remov molded spe	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.			_
L3001	Foot insert plastazote or eq	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.			_
L3002	Foot insert silicone gel eac	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  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.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.			_
L3140 L3150	Abduction rotation bar shoe  Abduct rotation bar w/o shoe	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	-	-
L3150	Shoe styled positioning dev	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  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.  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.  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.  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.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	-	-
L3219 L3221	Orthopedic mens shoes oxford Orthopedic mens shoes dpth i	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  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.  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.  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.	_	_	
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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.				
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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.			-	
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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.				
12540	Ortho choo add full colo					
L3540	Ortho shoe add full sole	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	_	_	
L3540 L3550	O shoe add standard toe tap	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	-	-	
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L3550	O shoe add standard toe tap	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	- - -	- - -	
L3550 L3560	O shoe add standard toe tap O shoe add horseshoe toe tap	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	-	-	
L3550 L3560 L3570 L3580	O shoe add standard toe tap O shoe add horseshoe toe tap O shoe add instep extension O shoe add instep velcro clo	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.		_ _ _ _	- - - -	
L3550 L3560 L3570 L3580 L3590	O shoe add standard toe tap O shoe add horseshoe toe tap O shoe add instep extension O shoe add instep velcro clo O shoe convert to sof counte	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	- - - -	- - - -	-	
L3550 L3560 L3570 L3580 L3590 L3595	O shoe add standard toe tap O shoe add horseshoe toe tap O shoe add instep extension O shoe add instep velcro clo O shoe convert to sof counte Ortho shoe add march bar	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	- - - -	-	-	
L3550 L3560 L3570 L3580 L3590 L3595 L3600	O shoe add standard toe tap O shoe add horseshoe toe tap O shoe add instep extension O shoe add instep velcro clo O shoe convert to sof counte Ortho shoe add march bar Trans shoe calip plate exist	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	- - - - - -	-	- - - - - -	
L3550 L3560 L3570 L3580 L3590 L3595	O shoe add standard toe tap O shoe add horseshoe toe tap O shoe add instep extension O shoe add instep velcro clo O shoe convert to sof counte Ortho shoe add march bar	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	-	-	
L3550 L3560 L3570 L3580 L3590 L3595 L3600	O shoe add standard toe tap O shoe add horseshoe toe tap O shoe add instep extension O shoe add instep velcro clo O shoe convert to sof counte Ortho shoe add march bar Trans shoe calip plate exist	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	-	-	
L3550 L3560 L3570 L3580 L3590 L3595 L3600 L3610	O shoe add standard toe tap O shoe add horseshoe toe tap O shoe add instep extension O shoe add instep velcro clo O shoe convert to sof counte Ortho shoe add march bar Trans shoe calip plate exist Trans shoe caliper plate new	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	-	-	
L3550 L3560 L3570 L3580 L3590 L3595 L3600 L3610 L3620 L3630	O shoe add standard toe tap O shoe add horseshoe toe tap O shoe add instep extension O shoe add instep velcro clo O shoe convert to sof counte Ortho shoe add march bar Trans shoe calip plate exist Trans shoe caliper plate new Trans shoe solid stirrup exi Trans shoe solid stirrup new	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	-	-	
L3550 L3560 L3570 L3580 L3590 L3595 L3600 L3610 L3620 L3630 L3640	O shoe add standard toe tap O shoe add horseshoe toe tap O shoe add instep extension O shoe add instep velcro clo O shoe convert to sof counte Ortho shoe add march bar Trans shoe calip plate exist Trans shoe caliper plate new Trans shoe solid stirrup exi Trans shoe solid stirrup new Shoe dennis browne splint bo	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	- - - - - - - - -		
L3550 L3560 L3570 L3580 L3590 L3595 L3600 L3610 L3620 L3630 L3640 L3649	O shoe add standard toe tap O shoe add horseshoe toe tap O shoe add instep extension O shoe add instep velcro clo O shoe convert to sof counte Ortho shoe add march bar Trans shoe calip plate exist Trans shoe caliper plate new Trans shoe solid stirrup exi Trans shoe solid stirrup new Shoe dennis browne splint bo Orthopedic shoe modifica NOS	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-		-	
L3550 L3560 L3570 L3580 L3590 L3595 L3600 L3610 L3620 L3640	O shoe add standard toe tap O shoe add horseshoe toe tap O shoe add instep extension O shoe add instep velcro clo O shoe convert to sof counte Ortho shoe add march bar Trans shoe calip plate exist Trans shoe caliper plate new Trans shoe solid stirrup exi Trans shoe solid stirrup new Shoe dennis browne splint bo	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	-			
L3550 L3560 L3570 L3580 L3590 L3595 L3600 L3610 L3620 L3640 L3649	O shoe add standard toe tap O shoe add horseshoe toe tap O shoe add instep extension O shoe add instep velcro clo O shoe convert to sof counte Ortho shoe add march bar Trans shoe calip plate exist Trans shoe caliper plate new Trans shoe solid stirrup exi Trans shoe solid stirrup new Shoe dennis browne splint bo Orthopedic shoe modifica NOS	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	- - - - - - - - - -			
L3550 L3560 L3570 L3580 L3590 L3595 L3600 L3610 L3620 L3630 L3640 L3649 L3699 L5610	O shoe add standard toe tap O shoe add horseshoe toe tap O shoe add instep extension O shoe add instep velcro clo O shoe convert to sof counte Ortho shoe add march bar Trans shoe calip plate exist Trans shoe caliper plate new Trans shoe solid stirrup exi Trans shoe solid stirrup exi Orthopedic shoe modifica NOS Upper limb orthosis NOS Above knee hydracadence	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	-			
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Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	L5966	Hip flexible cover system	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK 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		_	_	_
Kecommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Foot external keel sach foot Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Espiral Flexible keel foot Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Espiral Ank-foot sys dors-plant flex Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Espiral Ank-foot sys dors-plant flex Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Espiral Ank-foot sys dors-plant flex Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Espiral Foot single axis ankle/foot Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria.  Foot single axis ankle/foot Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria.  Foot single axis ankle/foot Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria.  Foot single axis ankle/foot Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria.  Foot single axis ankle/foot Medical Policy Criteria: Procedure/service reviewed to ensure each 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			
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LS9/2 Flexible keel foot Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Recom	L5970	Foot external keel sach foot	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	L5972	Flexible keel foot		_	_	_
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	L59/4	root single axis ankle/foot		-	-	_

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.			
5978	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
L5980	Flex foot system	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	_	_	_
L5984	Endoskeletal axial rotation	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
L5985	Lwr ext dynamic prosth pylon	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
L6611	Additional switch ext power	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
L6621	Flex/ext wrist w/wo friction	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)	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
	Initial Issue Or Replacement ELECTRIC HAND SWITCH OR	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.			
	MYOLELECTRIC CONTROLLED				
L6880	INDEPENDENTLY ARTICULATING DIGITS ANY GRASP PATTERN OR	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
	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			
L6882	Microprocessor control uplmb	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
L6935	Below elbow myoelectronic ct	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
L6955	Above elbow myoelectronic ct	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
L6960	Shldr disartic switch contro	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
L6975	Interscap-thor myoelectronic	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	_	_	_
17040	Doob on all a set on to a	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
L7040	Prehensile actuator	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
L7045	Pediatric electric hook	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	_	_	_
	Electronic elbo simultaneous	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
L7181		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
L7185	Electron elbow adolescent sw	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	_	_	_
L7191	Elbow child myoelectronic ct	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	_	
	Libow crina myoelectronic ct	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
L7259	Electronic wrist rotator any	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			-
L7364	Twelve volt battery utah/equ	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
L7366	Battery chrgr 12 volt utah/e	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	_	_	_
-	, 0-	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.	_	_	_	
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a				
L7900	Male vacuum erection system	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-	
17002	Tonsian Ding Vac Front Day	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy Criteria. BCBSOK recommends submitting a				
L7902	Tension Ring Vac Erect Dev	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).	_	_	_	
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy Criteria. BCBSOK recommends submitting a				
L8606	Synthetic implnt urinary 1ml	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	_	_	
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy Criteria. BCBSOK recommends submitting a				
L8607	Inj vocal cord bulking agent	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-	
L8608	Ara ii out com/sun/oce mice	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-				
Lobus	Arg ii ext com/sup/acc misc	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.  Medical Delicy Citation, Presenting the Communication of the Communicati				
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.	_	_	_	
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets DESOK Medical Policy criteria. BCBSOK recommends submitting a				
L8680	Implt neurostim elctr each	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-	
10004	Dt negem for !!t ''	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy Criteria. BCBSOK recommends submitting a				
L8681	Pt prgrm for implt neurostim	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-		
L8682	Implt neurostim radiofg rec	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a				
L0002	impic neurosciin radiotq rec	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.  Medical Policy Criteria: Procedure (service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-			-
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.	-	-	_	
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a				
L8698	Misc used with tot art heart	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.				
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy Criteria. BCBSOK recommends submitting a				
L8701	Ewh s/d uprt micro sensor	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-	
	= 16 (t	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a				
L8702	Ewhf s/d uprt micro sensor	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.				
	топенти интегру	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-				
M0076	Prolotherapy	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	-	-	-	
M0100	Intragastric hypothermia	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.				
				_	_	
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets RCRSOK Medical Policy criteria. RCRSOK recommends submitting a	-			
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.	-	_	_	
		Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-	
M1150	Lvef <=40% or mod/sev I vsf	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	- - -	-	-	
M1150 M1151	Lvef <=40% or mod/sev l vsf Pt w/ hx trnsplt or lvad	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	- - -	- - -		
M1150	Lvef <=40% or mod/sev I vsf	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	- - -	- - -	-	
M1150 M1151	Lvef <=40% or mod/sev l vsf Pt w/ hx trnsplt or lvad	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	- - - -	- - - -	-	
M1150 M1151 M1152 M1153	Lvef <=40% or mod/sev I vsf Pt w/ hx trnspit or Ivad Pt w/ hx trnspit or Ivad Pt w/ dx osteo doe	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	- - - -	- - -	-	
M1150 M1151 M1152 M1153 M1154	Lvef <=40% or mod/sev I vsf Pt w/ hx trnsplt or Ivad Pt w/ hx trnsplt or Ivad Pt w/ hx trnsplt or Ivad Pt w/ dx osteo doe Hospc serv dur meas pd	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	- - - - -	- - - -	-	
M1150 M1151 M1152 M1153	Lvef <=40% or mod/sev I vsf Pt w/ hx trnspit or Ivad Pt w/ hx trnspit or Ivad Pt w/ dx osteo doe	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	-	-	
M1150 M1151 M1152 M1153 M1154	Lvef <=40% or mod/sev I vsf Pt w/ hx trnsplt or Ivad Pt w/ hx trnsplt or Ivad Pt w/ hx trnsplt or Ivad Pt w/ dx osteo doe Hospc serv dur meas pd	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	- - - - -	- - - -	-	
M1150 M1151 M1152 M1153 M1154 M1155	Lvef <=40% or mod/sev I vsf Pt w/ hx trnsplt or Ivad Pt w/ hx trnsplt or Ivad Pt w/ hx trnsplt or Ivad Pt w/ dx osteo doe Hospc serv dur meas pd Pt anphx due to pneum	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	-	-	
M1150 M1151 M1152 M1153 M1154 M1155 M1156	Lvef <=40% or mod/sev I vsf Pt w/ hx trnspit or Ivad Pt w/ hx trnspit or Ivad Pt w/ hx trnspit or Ivad Pt w/ dx osteo doe Hospc serv dur meas pd Pt anphx due to pneum Pt recd actv chemo any time	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	-	-	
M1150 M1151 M1152 M1153 M1154 M1155 M1156 M1157 M1158	Lvef <=40% or mod/sev l vsf Pt w/ hx trnsplt or lvad Pt w/ hx trnsplt or lvad Pt w/ hx trnsplt or lvad Pt w/ dx osteo doe Hospc serv dur meas pd Pt anphx due to pneum Pt recd actv chemo any time Pt recd bone mar trnsplt Pt hx immcomp prior/dur pd	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.		-	-	
M1150 M1151 M1152 M1153 M1154 M1155 M1156 M1157 M1158 M1159	Lvef <=40% or mod/sev l vsf Pt w/ hx trnsplt or lvad Pt w/ hx trnsplt or lvad Pt w/ hx trnsplt or lvad Pt w/ dx osteo doe Hospc serv dur meas pd Pt anphx due to pneum Pt recd actv chemo any time Pt recd bone mar trnsplt Pt hx immcomp prior/dur pd Hospc serv dur meas pd	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	- - - - - - -	-	
M1150 M1151 M1152 M1153 M1154 M1155 M1156 M1157 M1158	Lvef <=40% or mod/sev l vsf Pt w/ hx trnsplt or lvad Pt w/ hx trnsplt or lvad Pt w/ hx trnsplt or lvad Pt w/ dx osteo doe Hospc serv dur meas pd Pt anphx due to pneum Pt recd actv chemo any time Pt recd bone mar trnsplt Pt hx immcomp prior/dur pd	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	-		
M1150 M1151 M1152 M1153 M1154 M1155 M1156 M1157 M1158 M1159	Lvef <=40% or mod/sev l vsf Pt w/ hx trnsplt or lvad Pt w/ hx trnsplt or lvad Pt w/ hx trnsplt or lvad Pt w/ dx osteo doe Hospc serv dur meas pd Pt anphx due to pneum Pt recd actv chemo any time Pt recd bone mar trnsplt Pt hx immcomp prior/dur pd Hospc serv dur meas pd	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-			
M1150 M1151 M1152 M1153 M1154 M1155 M1156 M1157 M1158 M1159 M1160 M1161	Lvef <=40% or mod/sev l vsf Pt w/ hx trnsplt or lvad Pt w/ hx trnsplt or lvad Pt w/ hx trnsplt or lvad Pt w/ dx osteo doe Hospc serv dur meas pd Pt anphx due to pneum Pt recd actv chemo any time Pt recd bone mar trnsplt Pt hx immcomp prior/dur pd Hospc serv dur meas pd Pt anphx due to mengb bef 13	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-			
M1150 M1151 M1152 M1153 M1154 M1155 M1156 M1157 M1158 M1159 M1160 M1161 M1161	Lvef <=40% or mod/sev l vsf Pt w/ hx trnspit or lvad Pt w/ hx trnspit or lvad Pt w/ hx trnspit or lvad Pt w/ dx osteo doe Hospc serv dur meas pd Pt anphx due to pneum Pt recd actv chemo any time Pt recd bone mar trnspit Pt hx immcomp prior/dur pd Hospc serv dur meas pd Pt anphx due to mengb bef 13 Pt anphx due to dtp bef 13	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	- - - - - - - - - - - - -	-		
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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.			-
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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	lxv 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			-	_	-
	lxv nrs vrs iqa >=4	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  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			
F2031	rian analysis	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-	_	_	_
P9099	Blood component/product noc	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.			
Q0035		Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.			-
Q0033	Cardiokymography	Non-covered. Procedure/service not covered by BCBSOK. Not subject to drinzation review.	_	-	-
		N. O. J. D. J. J. J. J. BORGOV N. J.			
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.	_	-	-
			- - -	- - -	
Q0115	Post-coital mucous exam	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	- - -	- - -	- - -
Q0115 Q0243	Post-coital mucous exam casirivimab and imdevimab	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	- - -	- - -	
Q0115 Q0243 Q0244 Q0245	Post-coital mucous exam casirivimab and imdevimab Casirivi and imdevi 1200 mg bamlanivimab and etesevima	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	- - - -	- - - -	- - - -
Q0115 Q0243 Q0244	Post-coital mucous exam casirivimab and imdevimab Casirivi and imdevi 1200 mg	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	- - - -	- - - -	- - - -
Q0115 Q0243 Q0244 Q0245	Post-coital mucous exam casirivimab and imdevimab Casirivi and imdevi 1200 mg bamlanivimab and etesevima	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	- - - - -	- - - -	
Q0115 Q0243 Q0244 Q0245 Q0477	Post-coital mucous exam casirivimab and imdevimab Casirivi and imdevi 1200 mg bamlanivimab and etesevima Pwr module pt cable Ivad rpl Power adapter combo vad	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.		-	- - - - -
Q0115 Q0243 Q0244 Q0245 Q0477	Post-coital mucous exam casirivimab and imdevimab Casirivi and imdevi 1200 mg bamlanivimab and etesevima Pwr module pt cable lvad rpl	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. RCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. RCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	- - - - -	- - - - -
Q0115 Q0243 Q0244 Q0245 Q0477	Post-coital mucous exam casirivimab and imdevimab Casirivi and imdevi 1200 mg bamlanivimab and etesevima Pwr module pt cable Ivad rpl Power adapter combo vad	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria.	-	-	-
Q0115 Q0243 Q0244 Q0245 Q0477 Q0478 Q0479	Post-coital mucous exam casirivimab and imdevimab Casirivi and imdevi 1200 mg bamlanivimab and etesevima Pwr module pt cable Ivad rpl Power adapter combo vad Power module combo vad rep Driver pneumatic vad rep	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
Q0115 Q0243 Q0244 Q0245 Q0477 Q0478 Q0479	Post-coital mucous exam casirivimab and imdevimab Casirivi and imdevi 1200 mg bamlanivimab and etesevima Pwr module pt cable lvad rpl Power adapter combo vad Power module combo vad rep	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria.	-	-	-
Q0115 Q0243 Q0244 Q0245 Q0477 Q0478 Q0479 Q0480	Post-coital mucous exam casirivimab and imdevimab Casirivi and imdevi 1200 mg bamlanivimab and etesevima Pwr module pt cable Ivad rpl Power adapter combo vad Power module combo vad rep Driver pneumatic vad rep Micropress cu elec vad rep	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
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Q0115 Q0243 Q0244 Q0245 Q0477 Q0478 Q0479 Q0480 Q0481 Q0482 Q0483 Q0485 Q0486 Q0487 Q0489 Q0490 Q0491 Q0492 Q0493 Q0494 Q0495 Q0496 Q0497	Post-coital mucous exam casirivimab and imdevimab Casirivi and imdevi 1200 mg bamlanivimab and etesevima Pwr module pt cable Ivad rpl Power adapter combo vad Power module combo vad rep Driver pneumatic vad rep Microprcsr cu clec vad rep Microprcsr cu combo vad rep Monitor elec vad rep Monitor elec vad rep Monitor cable elec vad rep  Morable elec/pneum vad rep Leads any type vad rep only Pwr pack base elec vad rep Emr pwr source elec vad rep Emr pwr source elec vad rep Emr pwr cbl elec vad rep Emr pwr cbl combo vad rep Emr phyr cbl combo vad rep Emr hd pmp elec/combo rep Charger elec/combo vad rep Battery elec/combo vad rep Battery elec/combo vad rep	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Medical Policy Criteria: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends under the service meets BCBSOK Medical Policy criteria. BCBSOK recommends under the service meets BCBSOK Medical Policy criteria. BCBSOK recommends under the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the servic	- - - - - - - - - - - -		- - - - - - - - -
Q0115 Q0243 Q0244 Q0245 Q0477 Q0478 Q0479 Q0480 Q0481 Q0482 Q0483 Q0484 Q0485 Q0486 Q0487 Q0488 Q0489 Q0490 Q0491 Q0492 Q0493 Q0494 Q0495	Post-coital mucous exam casirivimab and imdevimab Casirivi and imdevi 1200 mg bamlanivimab and etesevima Pwr module pt cable Ivad rpl Power adapter combo vad Power module combo vad rep Driver pneumatic vad rep Microprcsr cu elec vad rep Microprcsr cu combo vad rep Monitor elec vad rep Monitor elec or comb vad rep Monitor cable elec vad rep Pwr pack base elec vad rep Emr pwr source elec vad rep Emr pwr cbl elec vad rep Emr pwr cbl combo vad rep Emr hd pmp elec/combo vad rep Emr hd pmp elec/combo vad rep	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Modical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recomm	- - - - - - - - - - - -		- - - - - - - - -

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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
Q0502	Mobility cart pneum vad rep	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	_	_	_
00506	Ush in both dealers was MAD	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
Q0506	Lith-ion batt elec/pneum VAD	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
Q0507	Misc sup/acc ext VAD	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
Q0508	Misc sup/acc imp VAD	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
Q0509	Mis sup/ac imp VAD nopay med	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			-
Q2028	Inj sculptra 0.5mg	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	_	_
Q2041	Axicabtagene ciloleucel car+	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q2050	Doxorubicin inj 10mg	Prior Authorization may be required per contract agreement.  Unlisted Procedure; May require Prior Authorization per contract agreement.			
Q2052	lvig demo services/supplies	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.		_	_
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
Q2053	Brexucabtagene car pos t	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.			
Q2054	Lisocabtagene mara car pos t	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 Q4051	Cast supplies unlisted  Splint supplies misc	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.  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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			_
Q4101	Apligraf	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).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			-
Q4105	Integra drt or omnigraft	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
Q4106	Dermagraft	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	_	_	_
Q4110	Primatrix	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			
		Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
Q4111	Gammagraft	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.	-		-
	Allestic	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			
Q4115	Alloskin	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	-	-	-
Q4115 Q4116	Alloskin Alloderm	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	-
		Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a  Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	- -	-	-
Q4116	Alloderm	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	- - -	-	-
Q4116 Q4117 Q4118	Alloderm Hyalomatrix Matristem micromatrix	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by 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 Q4117	Alloderm Hyalomatrix	Reimbursable Experimental, Investigational and/of Unproven Services (EIU).  Medical Policy Criteria. Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by 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 Q4117 Q4118	Alloderm  Hyalomatrix  Matristem micromatrix  Theraskin  Dermacell awm porous sq cm	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	- - - -	- - - -	- - - -
Q4116 Q4117 Q4118 Q4121	Alloderm Hyalomatrix Matristem micromatrix Theraskin Dermacell awm porous sq cm ALLOSKIN RT PER SQUARE	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	- - - -	- - - -	- - - -
Q4116 Q4117 Q4118 Q4121 Q4122 Q4123	Alloderm  Hyalomatrix  Matristem micromatrix  Theraskin  Dermacell awm porous sq cm  ALLOSKIN RT PER SQUARE CENTIMETER  OASIS ULTRA TRI-LAYER WOUND	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by 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 Q4117 Q4118 Q4121 Q4122 Q4123 Q4124	Alloderm  Hyalomatrix  Matristem micromatrix  Theraskin  Dermacell awm porous sq cm  ALLOSKIN RT PER SQUARE CENTIMETER	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by 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 Q4117 Q4118 Q4121 Q4122 Q4123	Alloderm  Hyalomatrix  Matristem micromatrix  Theraskin  Dermacell awm porous sq cm  ALLOSKIN RT PER SQUARE CENTIMETER OASIS ULTRA TRI-LAYER WOUND MATRIX PER SQUARE CENTIMETER	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by 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 Q4117 Q4118 Q4121 Q4122 Q4123 Q4124	Alloderm  Hyalomatrix  Matristem micromatrix  Theraskin  Dermacell awm porous sq cm  ALLOSKIN RT PER SQUARE CENTIMETER OASIS ULTRA TRI-LAYER WOUND MATRIX PER SQUARE CENTIMETER ARTHROFLEX PER SQUARE	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by 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 Q4117 Q4118 Q4121 Q4122 Q4123 Q4124 Q4125	Alloderm  Hyalomatrix  Matristem micromatrix  Theraskin  Dermacell awm porous sq cm  ALLOSKIN RT PER SQUARE CENTIMETER OASIS ULTRA TRI-LAYER WOUND MATRIX PER SQUARE CENTIMETER ARTHROFLEX PER SQUARE CENTIMETER	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational Review of Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see	- - - -	-	- - - - - - -

		Madisal Ballis Calasia Basada da sa			
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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
Q4133	Grafix stravix prime pl sqcm	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-	_	_	_
Q4136	EZderm	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			
		Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
Q4137	Amnioexcel biodexcel 1sq cm	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-			
04141	Allockin as 1 cm	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			
Q4141	Alloskin ac 1 cm	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
Q4142	Xcm biologic tiss matrix 1cm	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-	_	_	_
Q4146	Tensix 1cm	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			
		Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
Q4147	Architect ecm px fx 1 sq cm	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-	_	_	_
Q4150	Allowrap ds or dry 1 sq cm	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			
		Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
Q4151	Amnioband guardian 1 sq cm	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-	_	_	_
Q4154	Piovance 1 causes cm	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
	Biovance 1 square cm	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
Q4155	Neoxflo or clarixflo 1 mg	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).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
Q4159	Affinity1 square cm	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).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
Q4163	Woundex bioskin per sq cm	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).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
Q4167	Truskin per sq centimeter	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).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-		_
Q4171	Interfyl 1 mg	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
Q4173	Palingen or palingen xplus	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-	_	_	_
Q4176	Neopatch or therion per square	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			
	centimeter	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
Q4177	Floweramnioflo 0.1 cc	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-	_	_	_
Q4180	Revita per sq cm	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			
		Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
Q4181	Amnio wound per square cm	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-	_		_
Q4184	Cellesta or duo per sq cm	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			
		Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	_	
Q4185	Cellesta flowab amnion 0.5cc	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).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			
Q4189	Artacent ac 1 mg	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	_	-	-
Q4190	Artacent ac 1 sq cm	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-			
Q4194	Novachor 1 sq cm	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			
Q4194	Novaciior 1 sq ciii	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
Q4195	Puraply 1 sq cm	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-			_
	<u> </u>	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-		<u>-</u>
Q4199	Cygnus matrix per sq cm	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
Q4200	Skin te 1 sq cm	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-	_	_	_
Q4203	Derma-gide 1 sq cm	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			
_		Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			-
Q4204	Xwrap 1 sq cm	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
Q4205	Membrane graft or wrap sq cm	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).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			-
Q4210	Axoloti graf dualgraf sq cm	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
Q4211	Amnion bio or axobio sq cm	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).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			<del>-</del>
Q4215	Axolotl ambient cryo 0.1 mg	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
Q4216	Artacent cord per sq cm	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).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-		
Q4220	Bellacell HD Surederm sq cm	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
Q4221	Amniowrap2 per sq cm	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-	_		_
Q4227	Amniocore per sq cm	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	_	
		Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-	-	-
Q4229	Cogenex amnio memb per sq cm	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-			_
Q4233	Surfactor /nudyn per 0.5 cc	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	-		
		Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-		-	-
Q4234	Xcellerate per sq cm	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).	-	-	-

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West						
Company   Comp	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).	_	_	-
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1.	04220	Dorm mayy nor co.cm				
				-	_	-
March   Marc	Q4239	Amnio-maxx or lite per sq cm	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	-	-	-
	Q4240	Corecyte topical only 0.5 cc		-	-	-
Management   Man	Q4241	Polycyte topical only 0.5cc		_	_	_
10.000   Provided part 2017   10.000   Provided part 2017   10.000   Provided part 2017   P	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-			
10.1						-
	Q4244	Procenta per 200 mg		-	_	-
	Q4245	Amniotext per cc	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	-	-	-
	Q4246	Coretext or protext per cc		-	-	-
1982   Semantine mentant below   1897   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   1997   19	Q4247	Amniotext patch per sq cm		_	_	_
	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-			
Miles		· · · · · · · · · · · · · · · · · · ·				
West with the property of the comments of the property of the	Q4249	Annipiy per sq ciri		-	-	-
Part	Q4250	Amnioamp-mp per sq cm	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	-	-	-
Section   Processing   Control   C	Q4251	Vim per square centimeter		-	-	-
Author	Q4252	Vendaje per square centimet		_	_	_
	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-			
International Conference   Co						-
Segment regions in general and per sil.  Segment regions and per sil.  Proceed-person on communication of the segment regions.  Proceed-person on communication regions.  Proceed-person on communication regions.  Proceed-person on communication regions.  Proced-person	Q4254	· · ·		-	-	-
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inchange for Spring in Embalance beginned, incorporation and/or Uniquene Services (FU).    Proceeding for the commission of the Control Contro	Q4256	Mlg complet per sq cm		-	_	-
Camera per la commentation   Camera per la	Q4257	Relese per sq cm		_	_	_
Section of the sectio	04258	Enverse per sa cm	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			
Reministrate Ligarithmic March					_	-
Septiminal policy from the protection of the community of the protection of the prot	Q4259	Celera per sq cm		-	-	-
	Q4260	Signature apatch per sq cm	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	-	-	-
New York 1 per q m  Medical Palicy Criteria. Proceeding-review review design and process a	Q4261	Tag per square centimeter		-	-	-
Medical Policy Circuits: Procedur/private reviewed to ensure each service meets ECSCOM Medical Policy criteria. BCESON recommends submitting a measurement of the measurement of request if it is unclear if the service meets ECSCOM Medical Policy criteria. BCESON recommends submitting a measurement of the measurement	Q4262	Dual layer impax per sq cm		1/1/2023	_	Add effective 01/01/2023
Add effective O/I/1/2023  Add effective O/I/						
Notice that the process of the pro	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	1/1/2023		Add effective 01/01/2023
Medical Policy Critaria. Procedura/service reviewed to ensure each service meets SCRSOK Medical Policy criterias. RCRSOK recommends submitting a recommended formisal service meets and the service meets SCRSOK Medical Policy criteria. RCRSOK recommends submitting a recommended formisal service meets and service meets SCRSOK Medical Policy criteria. RCRSOK recommends submitting a recommended formisal service meets and service meets SCRSOK Medical Policy criteria. RCRSOK recommends submitting a recommended clinical Review (Predestimination) request if it is unclear if the service meets SCRSOK Medical Policy criteria. RCRSOK recommends submitting a recommended clinical Review (Predestimination) request if it is unclear if the service meets SCRSOK Medical Policy criteria. RCRSOK recommends submitting a recommended clinical Review (Predestimination) request if it is unclear if the service meets SCRSOK Medical Policy criteria. RCRSOK recommends submitting a recommended clinical Review (Predestimination) request if it is unclear if the service meets SCRSOK Medical Policy criteria. RCRSOK recommends submitting a recommended clinical Review (Predestimination) request if it is unclear if the service meets SCRSOK Medical Policy criteria. RCRSOK recommends submitting a recommended clinical Review (Predestimination) request if it is unclear if the service meets SCRSOK Medical Policy criteria. RCRSOK recommends submitting a recommended clinical Review (Predestimination) request if it is unclear if the service meets SCRSOK Medical Policy criteria. RCRSOK recommends submitting a recommended clinical Review (Predestimination) request if it is unclear if the service meets SCRSOK Medical Policy criteria. RCRSOK recommends submitting a recommended recommended recommended review meets RCRSOK Medical Policy criteria. RCRSOK recommends submitting a recommended clinical Review (Predestimination) request if it is unclear if the service meets RCRSOK Medical Policy criteria. RCRSOK recommends submitting a recommended clinical Review (Pred	Q4263		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.		-	
Price Authorization may be required per contract agreement.	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. Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.		-	
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Nonemerg transp mileage  Nonemerg transp milea	Q4264 Q5009 Q5103 Q5104 Q5109 Q5124 Q5125 Q9004 Q9982 Q9983 S0013 S0122 S0126 S0128 S0155 S0157 S0189 S0194 S0197	Cocoon membrane per sq cm Hospice care NOS Injection inflectra Injection renflexis Injection ixifi 10 mg Inj. byooviz 0.1 mg Inj. byooviz 0.1 mg Inj releuko 1 mcg Va whole health partner serv flutemetamol f18 diagnostic florbetaben f18 diagnostic Esketamine nasal spray Inj menotropins 75 iu Inj follitropin alfa 75 iu Inj follitropin beta 75 iu Epoprostenol dilutant Becaplermin gel 1% 0.5 gm Testosterone pellet 75 mg Dialysis/Stress Vitamin Supplement Oral100 Capsules Prenatal vitamins 30 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. Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK reco	1/1/2023		Add effective 01/01/2023
Notemerg transp mileage Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	Q4264 Q5009 Q5103 Q5104 Q5109 Q5124 Q5125 Q9004 Q9982 Q9983 S0013 S0122 S0126 S0128 S0157 S0189 S0194 S0197 S0207	Cocoon membrane per sq cm Hospice care NOS Injection inflectra Injection renflexis Injection ixifi 10 mg Inj. byooviz 0.1 mg Inj. byooviz 0.1 mg Inj releuko 1 mcg Va whole health partner serv flutemetamol f18 diagnostic florbetaben f18 diagnostic Esketamine nasal spray Inj menotropins 75 iu Inj follitropin alfa 75 iu Epoprostenol dilutant Becaplermin gel 1% 0.5 gm Testosterone pellet 75 mg Dialysis/Stress Vitamin Supplement Oral100 Capsules Prenatal vitamins 30 day Paramedicintercep nonhospals	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear i	1/1/2023		Add effective 01/01/2023
SO257 End of life counseling Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	Q4264 Q5009 Q5103 Q5104 Q5109 Q5124 Q5125 Q9004 Q9982 Q9983 S0013 S0122 S0126 S0128 S0155 S0157 S0189 S0194 S0207 S0209	Cocoon membrane per sq cm Hospice care NOS Injection inflectra Injection renflexis Injection ixifi 10 mg Inj. byooviz 0.1 mg Inj. byooviz 0.1 mg Inj releuko 1 mcg Va whole health partner serv flutemetamol f18 diagnostic florbetaben f18 diagnostic Esketamine nasal spray Inj menotropins 75 iu Inj follitropin alfa 75 iu Epoprostenol dilutant Becaplermin gel 1% 0.5 gm Testosterone pellet 75 mg Dialysis/Stress Vitamin Supplement Oral100 Capsules Prenatal vitamins 30 day Paramedicintercep nonhospals	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends collinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria.  Prior Authorization may be required per contract agreement.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria.  Prior Authorization may be required per contract agreement.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria.  Prior Authorization may be required per contract agreement.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria.  Prior Authorization may be required per contract agreement.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria.  Prior Authorization may be required per contract agreement.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not c	1/1/2023		Add effective 01/01/2023
	Q4264 Q5009 Q5103 Q5104 Q5109 Q5124 Q5125 Q9004 Q9982 Q9983 S0013 S0122 S0126 S0128 S0157 S0189 S0194 S0197 S0207 S0209 S0215	Cocoon membrane per sq cm Hospice care NOS Injection inflectra Injection renflexis Injection ixifi 10 mg Inj. byooviz 0.1 mg Inj. byooviz 0.1 mg Inj releuko 1 mcg Va whole health partner serv flutemetamol f18 diagnostic Esketamine nasal spray Inj menotropins 75 iu Inj follitropin alfa 75 iu Inj follitropin beta 75 iu Epoprostenol dilutant Becaplermin gel 1% 0.5 gm Testosterone pellet 75 mg Dialysis/Stress Vitamin Supplement Oral100 Capsules Prenatal vitamins 30 day Paramedicintercep nonhospals WC van mileage per mi Nonemerg transp mileage	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends abmitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. Medical Policy Criteria: Procedure/service mot otherwise defined or classified, and may be subject to benefit and/or clinical review.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Revi	1/1/2023		Add effective 01/01/2023

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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	-	-
S0800	Laser in situ keratomileusis	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	_	_	_
S1001	Deluxe item	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.			
S1002	Custom item	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.			
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	_	-
S1030	Gluc monitor purchase	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			
22004	c pana cas system	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure (service reviewed to ensure each service meets BCBSOK Medical Policy criteria, BCBSOK recommends submitting a	-	-	-
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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			-
S1037	Art pancreas ext receiver	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
S1091	Stent non-coronary propel	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 gestric hand	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy Criteria. BCBSOK recommends submitting a			
32063	Adjustment gastric band	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			
52102	isiet een tissue transplant	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
S2103	Adrenal tissue transplant	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
S2112	Knee arthroscp harv	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	Conditional homosphine	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
52140	Cord blood harvesting	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			
32130	DIVIT Harvy transpi 200 pkg	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
S2235	Implant auditory brain imp	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).	_	_	_
62240	December die DE lember	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
S2348	Decompress disc RF lumbar	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			
32401	. can sung arm trac outt	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			-
S2404	Fetal surg myelomeningo	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
S2409	Fetal surg noc	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
S2411	Fetoscop laser ther TTTS	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).  EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-	_		<del>-</del>
S3652	Saliva test hormone level;	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	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
33.22	Infusional 5-Fluorouracil	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	-	-	<u>-</u>

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.			_
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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.			
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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.			
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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.			
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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.			_
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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.			_
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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.	_	_	_
	Attendant care service /diem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.			_
\$5126	Accordant care service / diem				
S5126			-		
S5130	Homaker service nos per 15m	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.	_	_	-
	Homaker service nos per 15m Homemaker service nos /diem	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.  Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.	- -	-	- -
S5130			-	-	-
S5130 S5131 S5135	Homemaker service nos /diem	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	- - -	- - -	-
\$5130 \$5131 \$5135 \$5136	Homemaker service nos /diem Adult companioncare per 15m Adult companioncare per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	- - - -	-
\$5130 \$5131 \$5135 \$5136 \$5140	Homemaker service nos /diem Adult companioncare per 15m Adult companioncare per diem Adult foster care per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	- - - -	- - - -	-
\$5130 \$5131 \$5135 \$5136	Homemaker service nos /diem Adult companioncare per 15m Adult companioncare per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	- - - - -	- - - - -	-
\$5130 \$5131 \$5135 \$5136 \$5140	Homemaker service nos /diem Adult companioncare per 15m Adult companioncare per diem Adult foster care per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	-	-
\$5130 \$5131 \$5135 \$5136 \$5140 \$5141	Homemaker service nos /diem Adult companioncare per 15m Adult companioncare per diem Adult foster care per diem Adult foster care per month	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	- - - - -	-
\$5130 \$5131 \$5135 \$5136 \$5140 \$5141 \$5145	Homemaker service nos /diem Adult companioncare per 15m Adult companioncare per diem Adult foster care per diem Adult foster care per month Child fostercare th per diem	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	-	-
\$5130 \$5131 \$5135 \$5136 \$5140 \$5141 \$5145 \$5146 \$5150	Homemaker service nos /diem Adult companioncare per 15m Adult companioncare per diem Adult foster care per diem Adult foster care per month Child fostercare th per diem Ther fostercare child /month Unskilled respite care /15m	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	-	- - - - -
\$5130 \$5131 \$5135 \$5136 \$5140 \$5141 \$5145 \$5146 \$5150 \$5151	Homemaker service nos /diem Adult companioncare per 15m Adult companioncare per diem Adult foster care per diem Adult foster care per month Child fostercare th per diem Ther fostercare child /month Unskilled respite care /15m Unskilled respitecare /diem	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	- - - - - - -	-	- - - - - - -
\$5130 \$5131 \$5135 \$5136 \$5140 \$5141 \$5145 \$5146 \$5150 \$5151 \$5160	Homemaker service nos /diem Adult companioncare per 15m Adult companioncare per diem Adult foster care per diem Adult foster care per month Child fostercare th per diem Ther fostercare child /month Unskilled respite care /15m Unskilled respitecare /diem Emer response sys instal&tst	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	-	-
\$5130 \$5131 \$5135 \$5136 \$5140 \$5141 \$5145 \$5146 \$5150 \$5151	Homemaker service nos /diem Adult companioncare per 15m Adult companioncare per diem Adult foster care per diem Adult foster care per month Child fostercare th per diem Ther fostercare child /month Unskilled respite care /15m Unskilled respitecare /diem	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	- - - - - - - - -	- - - - - - - - - - - - - - - - - - -	
\$5130 \$5131 \$5135 \$5136 \$5140 \$5141 \$5145 \$5146 \$5150 \$5151 \$5160	Homemaker service nos /diem Adult companioncare per 15m Adult companioncare per diem Adult foster care per diem Adult foster care per month Child fostercare th per diem Ther fostercare child /month Unskilled respite care /15m Unskilled respitecare /diem Emer response sys instal&tst	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	-	-
\$5130 \$5131 \$5135 \$5136 \$5140 \$5141 \$5145 \$5146 \$5150 \$5151 \$5160 \$5161	Homemaker service nos /diem Adult companioncare per 15m Adult companioncare per diem Adult foster care per diem Adult foster care per month Child fostercare th per diem Ther fostercare child /month Unskilled respite care /15m Unskilled respitecare /diem Emer response sys instal&tst Emer rspns sys serv permonth	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-		-
\$5130 \$5131 \$5135 \$5136 \$5140 \$5141 \$5145 \$5146 \$5150 \$5151 \$5160 \$5161 \$5162 \$5165	Homemaker service nos /diem Adult companioncare per 15m Adult companioncare per diem Adult foster care per diem Adult foster care per month Child fostercare th per diem Ther fostercare child /month Unskilled respite care /15m Unskilled respitecare /diem Emer response sys instal&tst Emer rspns sys serv permonth Emer rspns system purchase Home modifications per serv	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.		- - - - - - - - - - - - - - - - - - -	- - - - - - - - - - - - -
\$5130 \$5131 \$5135 \$5136 \$5140 \$5141 \$5145 \$5146 \$5150 \$5151 \$5160 \$5161 \$5162 \$5165 \$5170	Homemaker service nos /diem Adult companioncare per 15m Adult companioncare per diem Adult foster care per diem Adult foster care per month Child fostercare th per diem Ther fostercare child /month Unskilled respite care /15m Unskilled respite care /diem Emer response sys instal&tst Emer rspns sys serv permonth Emer rspns system purchase Home modifications per serv Homedelivered prepared meal	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	- - - - - - - - - - - - - - - - - - -	- - - - - - - - - - - - - - - - - - -	
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\$5130 \$5131 \$5135 \$5136 \$5140 \$5141 \$5145 \$5146 \$5150 \$5151 \$5160 \$5161 \$5162 \$5165 \$5170	Homemaker service nos /diem Adult companioncare per 15m Adult companioncare per diem Adult foster care per diem Adult foster care per month Child fostercare th per diem Ther fostercare child /month Unskilled respite care /15m Unskilled respite care /diem Emer response sys instal&tst Emer rspns sys serv permonth Emer rspns system purchase Home modifications per serv Homedelivered prepared meal	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	- - - - - - - - - - - - - - - - - - -	- - - - - - - - - - - - - - - - - - -	
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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	Hippothorany per cossion	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			
36940	Hippotherapy per session	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.	_	_	_
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
S8990	Pt or manip for maint	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-			
55001	Tionic dictine monitor with or	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.	_	_	_
		EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-			
S9056	Coma stimulation per diem	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-			
	<u> </u>	Reimbursable Experimental, Investigational and/or Unproven Services (EIU).  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			-
S9117	Back school visit	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.			
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			-
S9128	Speech therapy in the home	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.	-	-	_
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy Criteria. BCBSOK recommends submitting a			
S9145	Insulin pump initiation	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	_	_	
	<u></u>	Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
S9340	HIT enteral per diem	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			
33341	Till eliteral grav tilelli	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
S9343	HIT enteral bolus nurs	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			
55555	THE CHEIGHEN GICH	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.	_	_	_
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			
S9366	HIT tpn 2 liter diem	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.  Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a			-
S9368	HIT tpn over 3l diem	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.			-
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	-	_	-
S9430	Pharmacy comp/disp serv	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.			
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a	_	_	
S9435	Medical foods for inborn err	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.  Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.		-	_
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S9442	Birthing class	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	-	-
S9444 S9445	Parenting class	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	