# Predetermination, Medical Necessity and Non-Covered Services
# 2022 Commercial Benefit Procedure Code List - Fully Insured

**Updated November 2022**

**EXCEPT AS OTHERWISE NOTED IN THE DATE COLUMN, THESE CODES ARE EFFECTIVE ON OR BEFORE JANUARY 1, 2022.**

Our medical policy impacts all our coverage decisions. This list includes Current Procedural Terminology (CPT®) and/or Healthcare Common Procedure Coding System (HCPCS) codes that, based on our medical policy, are:

- Subject to a medical necessity review,
- Candidates for a 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. All BCBSOK Medical Policies can be found at http://www.medicalpolicy.hcsc.net/medicalpolicy/index?corpEntCd=OK1

The purpose of a Predetermination request is to determine whether a specific service, including services that may be considered Experimental/Investigational/Unproven, is Medically Necessary. A 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 | Procedure Code Group Description |
|---|---|
| Medical Policy Criteria | Procedures and services are reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends sub |
| | Highlighted procedures/services in this code group may require prior authorization. Refer to prior authorization resources ava |
| Non Covered | Procedures/services not covered by BCBSOK. Not subject to utilization review. |
| Experimental, Investigational, Unprov | Procedures/services not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding |
| 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 | Medical Policy No. | Medical Policy Title | Effective Date | Ending Date |
|---|---|---|---|---|---|---|
| 00104 | Anesth Electroshock | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | PSY301.013 | Electroconvulsive Therapy | _ | _ |
| 00640 | Anesth Spine Manipulation | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE803.016 | Manipulation Under Anesthesia | _ | _ |
| 00797 | Anesth Surgery For Obesity | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.003 | Bariatric Surgery | _ | _ |
| 11055 | Trim Skin Lesion | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.006 | Foot Care Services | _ | _ |
| 11056 | Trim Skin Lesions 2 To 4 | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.006 | Foot Care Services | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 11057 | Trim Skin Lesions Over 4 | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.006 | Foot Care Services | _ | _ |
| 11200 | Removal Of Skin Tags <W/15 | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001 | Cosmetic and Reconstructive Procedures | _ | _ |
| 11201 | Remove Skin Tags Add-On | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001 | Cosmetic and Reconstructive Procedures | _ | _ |
| 11719 | Trim Nail(S) Any Number | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.006 | Foot Care Services | _ | _ |
| 11920 | Correct Skin Color 6.0 Cm/< | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001<br>SUR716.011 | Cosmetic and Reconstructive Procedures<br>Reconstructive and Contralateral Mammaplasty | _ | _ |
| 11921 | Correct Skn Color 6.1-20.0Cm | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001<br>SUR716.011 | Cosmetic and Reconstructive Procedures<br>Reconstructive and Contralateral Mammaplasty | _ | _ |
| 11922 | Correct Skin Color Ea 20.0Cm | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001<br>SUR716.011 | Cosmetic and Reconstructive Procedures<br>Reconstructive and Contralateral Mammaplasty | _ | _ |
| 11950 | Tx Contour Defects 1 Cc/< | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001<br>SUR717.001<br>SUR706.009 | Cosmetic and Reconstructive Procedures<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Sleep Related Breathing Disorders: Surgical Management | _ | _ |
| 11951 | Tx Contour Defects 1.1-5.0Cc | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001<br>SUR717.001<br>SUR706.009 | Cosmetic and Reconstructive Procedures<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Sleep Related Breathing Disorders: Surgical Management | _ | _ |
| 11952 | Tx Contour Defects 5.1-10Cc | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001<br>SUR717.001<br>SUR706.009 | Cosmetic and Reconstructive Procedures<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Sleep Related Breathing Disorders: Surgical Management | _ | _ |
| 11954 | Tx Contour Defects >10.0 Cc | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001<br>SUR717.001<br>SUR706.009 | Cosmetic and Reconstructive Procedures<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Sleep Related Breathing Disorders: Surgical Management | _ | _ |
| 11960 | Insert Tissue Expander(S) | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001 | Cosmetic and Reconstructive Procedures | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.009<br>SUR716.001<br>SUR716.011 | Breast Implant, Removal and/or Insertion<br>Cosmetic and Reconstructive Procedures<br>Reconstructive Breast Surgery | _ | _ |
| 11980 | Implant Hormone Pellet(S) | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.063<br>SUR717.001<br>RX501.007<br>RX501.076 | Compounded Drug Products<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Hormone Replacement Therapies (HRT) Using Implanted Pellets for Women and Delayed Puberty<br>Testosterone Replacement Therapies | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 11981 | Insert Drug Implant Device | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.082<br>RX501.007<br>SUR717.001<br>RX501.076 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Treatment of Opioid Dependence<br>Testosterone Replacement Therapies<br>Hormone Replacement Therapies (HRT) Using Implanted Pellets for Women and Delayed Puberty | | |
| 11982 | Remove Drug Implant Device | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.082<br>RX501.007<br>SUR717.001<br>RX501.076 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Treatment of Opioid Dependence<br>Testosterone Replacement Therapies<br>Hormone Replacement Therapies (HRT) Using Implanted Pellets for Women and Delayed Puberty | | |
| 11983 | Remove/Insert Drug Implant | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.082<br>RX501.007<br>SUR717.001<br>RX501.076 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Treatment of Opioid Dependence<br>Testosterone Replacement Therapies<br>Hormone Replacement Therapies (HRT) Using Implanted Pellets for Women and Delayed Puberty | | |
| 15758 | Free Fascial Flap Microvasc | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.024 | Surgery for Lipedema and Lymphedema | | |
| 15769 | Grfg Autol Soft Tiss Dir Exc | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.021<br>SUR716.011 | Reconstructive Breast Surgery<br>Adipose-Derived Stem Cells in Autologous Fat Grafting to the Breast | 1/15/2021 | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.021<br>SUR716.011 | Reconstructive Breast Surgery<br>Adipose-Derived Stem Cells in Autologous Fat Grafting to the Breast | 1/15/2021 | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.021<br>SUR716.011 | Reconstructive Breast Surgery<br>Adipose-Derived Stem Cells in Autologous Fat Grafting to the Breast | 1/15/2021 | |
| 15775 | Hair Trnspl 1-15 Punch Grfts | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001 | Cosmetic and Reconstructive Procedures | | |
| 15776 | Hair Trnspl >15 Punch Grafts | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001 | Cosmetic and Reconstructive Procedures | | |
| 15780 | Dermabrasion Total Face | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001<br>THE801.030<br>SUR717.001<br>THE801.028 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Cosmetic and Reconstructive Procedures<br>Nonpharmacologic Treatment of Rosacea<br>Acne Management | | |
| 15781 | Dermabrasion Segmental Face | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001<br>THE801.030<br>SUR717.001<br>THE801.028 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Cosmetic and Reconstructive Procedures<br>Nonpharmacologic Treatment of Rosacea<br>Acne Management | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| 15782 | Dermabrasion Other Than Face | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001<br>THE801.030<br>SUR717.001<br>THE801.028 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Cosmetic and Reconstructive Procedures<br>Nonpharmacologic Treatment of Rosacea<br>Acne Management | _ | _ |
| 15783 | Dermabrasion Suprfl Any Site | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001<br>THE801.030<br>SUR717.001<br>THE801.028 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Cosmetic and Reconstructive Procedures<br>Nonpharmacologic Treatment of Rosacea<br>Acne Management | _ | _ |
| 15786 | Abrasion Lesion Single | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001<br>SUR717.001<br>THE801.028 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Cosmetic and Reconstructive Procedures<br>Acne Management | _ | _ |
| 15787 | Abrasion Lesions Add-On | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001<br>SUR717.001<br>THE801.028 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Cosmetic and Reconstructive Procedures<br>Acne Management | _ | _ |
| 15788 | Chemical Peel Face Epiderm | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.018<br>THE801.030<br>SUR717.001<br>THE801.028 | Chemical Peels<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Nonpharmacologic Treatment of Rosacea<br>Acne Management | _ | _ |
| 15789 | Chemical Peel Face Dermal | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.018<br>THE801.030<br>SUR717.001<br>THE801.028 | Chemical Peels<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Nonpharmacologic Treatment of Rosacea<br>Acne Management | _ | _ |
| 15792 | Chemical Peel Nonfacial | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.018<br>THE801.030<br>SUR717.001<br>THE801.028 | Chemical Peels<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Nonpharmacologic Treatment of Rosacea<br>Acne Management | _ | _ |
| 15793 | Chemical Peel Nonfacial | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.018<br>THE801.030<br>SUR717.001<br>THE801.028 | Chemical Peels<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Nonpharmacologic Treatment of Rosacea<br>Acne Management | _ | _ |
| 15819 | Plastic Surgery Neck | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| 15820 | Revision Of Lower Eyelid | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR717.001<br>SUR716.004 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Blepharoplasty, Blepharoptosis and Brow Repair | _ | _ |
| 15821 | Revision Of Lower Eyelid | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR717.001<br>SUR716.004 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Blepharoplasty, Blepharoptosis and Brow Repair | _ | _ |
| 15822 | Revision Of Upper Eyelid | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR717.001<br>SUR716.004 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Blepharoplasty, Blepharoptosis and Brow Repair | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 15823 | Revision Of Upper Eyelid | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR717.001<br>SUR716.004 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Blepharoplasty, Blepharoptosis and Brow Repair | _ | _ |
| 15824 | Removal Of Forehead Wrinkles | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR716.001<br>SUR712.031<br>SUR717.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Surgical Deactivation of Headache Trigger Sites<br>Cosmetic and Reconstructive Procedures | _ | _ |
| 15825 | Removal Of Neck Wrinkles | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001<br>SUR717.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Cosmetic and Reconstructive Procedures | _ | _ |
| 15826 | Removal Of Brow Wrinkles | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR716.001<br>SUR712.031<br>SUR717.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Surgical Deactivation of Headache Trigger Sites<br>Cosmetic and Reconstructive Procedures | _ | _ |
| 15828 | Removal Of Face Wrinkles | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001<br>SUR717.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Cosmetic and Reconstructive Procedures | _ | _ |
| 15829 | Removal Of Skin Wrinkles | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001 | Cosmetic and Reconstructive Procedures | _ | _ |
| 15830 | Exc Skin Abd | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001<br>SUR717.001<br>SUR701.024 | Cosmetic and Reconstructive Procedures<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Surgery for Lipedema and Lymphedema | _ | _ |
| 15832 | Excise Excessive Skin Thigh | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001<br>SUR701.024<br>SUR717.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Cosmetic and Reconstructive Procedures<br>Surgery for Lipedema and Lymphedema | _ | _ |
| 15833 | Excise Excessive Skin Leg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001<br>SUR701.024<br>SUR717.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Cosmetic and Reconstructive Procedures<br>Surgery for Lipedema and Lymphedema | _ | _ |
| 15834 | Excise Excessive Skin Hip | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001<br>SUR701.024<br>SUR717.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Cosmetic and Reconstructive Procedures<br>Surgery for Lipedema and Lymphedema | _ | _ |
| 15835 | Excise Excessive Skin Buttck | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001<br>SUR701.024<br>SUR717.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Cosmetic and Reconstructive Procedures<br>Surgery for Lipedema and Lymphedema | _ | _ |
| 15836 | Excise Excessive Skin Arm | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001<br>SUR701.024<br>SUR717.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Cosmetic and Reconstructive Procedures<br>Surgery for Lipedema and Lymphedema | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001<br>SUR701.024<br>SUR717.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Cosmetic and Reconstructive Procedures<br>Surgery for Lipedema and Lymphedema | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001<br>SUR701.024<br>SUR717.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Cosmetic and Reconstructive Procedures<br>Surgery for Lipedema and Lymphedema | _ | _ |
| 15839 | Excise Excess Skin & Tissue | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001<br>SUR716.017<br>SUR701.024<br>SUR717.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Cosmetic and Reconstructive Procedures<br>Surgical Treatment of Gynecomastia<br>Surgery for Lipedema and Lymphedema | _ | _ |
| 15847 | Exc Skin Abd Add-On | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001<br>SUR701.024 | Cosmetic and Reconstructive Procedures<br>Surgery for Lipedema and Lymphedema | _ | _ |
| 15876 | Suction Lipectomy Head&Neck | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001<br>SUR701.024<br>SUR717.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Cosmetic and Reconstructive Procedures<br>Surgery for Lipedema and Lymphedema | _ | _ |
| 15877 | Suction Lipectomy Trunk | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001<br>SUR701.024<br>SUR717.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Cosmetic and Reconstructive Procedures<br>Surgery for Lipedema and Lymphedema | _ | _ |
| 15878 | Suction Lipectomy Upr Extrem | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001<br>SUR701.024<br>SUR717.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Cosmetic and Reconstructive Procedures<br>Surgery for Lipedema and Lymphedema | _ | _ |
| 15879 | Suction Lipectomy Lwr Extrem | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001<br>SUR701.024<br>SUR717.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Cosmetic and Reconstructive Procedures<br>Surgery for Lipedema and Lymphedema | _ | _ |
| 15999 | Removal Of Pressure Sore | 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE801.030<br>THE801.028<br>SUR704.008 | Laser Treatment of Congenital Port Wine Stain (PWS), Hemangiomas, and Other External Vascular Malformations<br>Nonpharmacologic Treatment of Rosacea<br>Acne Management | _ | _ |
| 17107 | Destruction Of Skin Lesions | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE801.030<br>THE801.028<br>SUR704.008 | Laser Treatment of Congenital Port Wine Stain (PWS), Hemangiomas, and Other External Vascular Malformations<br>Nonpharmacologic Treatment of Rosacea<br>Acne Management | _ | _ |
| 17108 | Destruction Of Skin Lesions | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE801.030<br>THE801.028<br>SUR704.008 | Laser Treatment of Congenital Port Wine Stain (PWS), Hemangiomas, and Other External Vascular Malformations<br>Nonpharmacologic Treatment of Rosacea<br>Acne Management | _ | _ |
| 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). | THE801.028 | Acne Management | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 17360 | Skin Peel Therapy | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE801.028 | Acne Management | _ | _ |
| 17380 | Hair Removal By Electrolysis | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001<br>SUR717.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Cosmetic and Reconstructive Procedures | _ | _ |
| 17999 | Skin Tissue Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 19105 | Cryosurg Ablate Fa Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.018 | Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors | _ | _ |
| 19300 | Removal Of Breast Tissue | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.017 | Surgical Treatment of Gynecomastia | _ | _ |
| 19303 | Mast Simple Complete | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.015<br>SUR717.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Prophylactic Mastectomy (PM)/Risk-Reducing Mastectomy (RRM) | _ | _ |
| 19316 | Suspension Of Breast | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR716.011<br>SUR717.001<br>SUR716.010 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Mastopexy<br>Reconstructive and Contralateral Mammaplasty | _ | _ |
| 19318 | Breast Reduction | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR716.001<br>SUR717.001<br>SUR716.011<br>SUR716.012 | Cosmetic and Reconstructive Procedures<br>Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Reconstructive and Contralateral Mammaplasty<br>Reduction Mammoplasty | _ | _ |
| 19325 | Breast Augmentation W/Implt | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.011<br>SUR717.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Reconstructive and Contralateral Mammaplasty | _ | _ |
| 19328 | Rmvl Intact Breast Implant | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.009<br>SUR716.011 | Breast Implant, Removal and/or Insertion<br>Reconstructive and Contralateral Mammaplasty | _ | _ |
| 19330 | Rmvl Ruptured Breast Implant | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.009<br>SUR716.011 | Breast Implant, Removal and/or Insertion<br>Reconstructive and Contralateral Mammaplasty | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.009<br>SUR716.011<br>SUR717.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Breast Implant, Removal and/or Insertion<br>Reconstructive and Contralateral Mammaplasty | _ | _ |
| 19342 | Insj/Rplcmt Brst Implt Sep D | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.009<br>SUR716.011<br>SUR717.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Breast Implant, Removal and/or Insertion<br>Reconstructive and Contralateral Mammaplasty | _ | _ |
| 19350 | Breast Reconstruction | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.011<br>SUR717.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Reconstructive and Contralateral Mammaplasty | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 19355 | Correct Inverted Nipple(S) | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001 | Cosmetic and Reconstructive Procedures | _ | _ |
| 19357 | Tiss Xpndr Plmt Brst Rcnstj | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.011 | Reconstructive and Contralateral Mammaplasty | _ | _ |
| 19370 | Revj Peri-Implt Capsule Brst | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.011 | Reconstructive and Contralateral Mammaplasty | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.009<br>SUR716.011 | Breast Implant, Removal and/or Insertion<br>Reconstructive and Contralateral Mammaplasty | _ | _ |
| 19499 | Breast Surgery Procedure | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.021<br>SUR716.011<br>SUR701.031<br>SUR701.037 | Laser Interstitial Tumor Therapy (LITT/ILT) and Laser Ablation<br>Adipose-Derived Stem Cells in Autologous Fat Grafting to the Breast<br>Handheld Radiofrequency Spectroscopy for Intraoperative Assessment of Surgical Margins During Breast-Conserving Surgery<br>Reconstructive and Contralateral Mammaplasty | _ | _ |
| 20527 | Inj Dupuytren Cord W/Enzyme | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.073 | Clostridial Collagenase for Fibroproliferative Disorders | _ | _ |
| 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). | SUR702.018 | Dry Needling of Trigger Points for Myofascial Pain | _ | _ |
| 20561 | Ndl Insj W/O Njx 3+ Musc | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR702.018 | Dry Needling of Trigger Points for Myofascial Pain | _ | _ |
| 20930 | Sp Bone Algrft Morsel Add-On | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.038<br>SUR712.036<br>SUR703.051<br>SUR712.041<br>SUR705.039 | Bone Morphogenetic Protein<br>Orthopedic Applications of Stem-Cell Therapy<br>Use of i-Factor Peptide Enhanced Bone Graft<br>During Spinal Surgery<br>Lumbar Spinal Fusion<br>Cervical Spinal Fusion | _ | Moved to PA list |
| 20931 | Sp Bone Algrft Struct Add-On | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.038<br>SUR712.036 | Bone Morphogenetic Protein<br>Lumbar Spinal Fusion | _ | Moved to PA list |
| 20936 | Sp Bone Agrft Local Add-On | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR712.041<br>SUR712.036 | Lumbar Spinal Fusion<br>Cervical Spinal Fusion | _ | Moved to PA list |
| 20937 | Sp Bone Agrft Morsel Add-On | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR712.036 | Lumbar Spinal Fusion | _ | Moved to PA list |
| 20938 | Sp Bone Agrft Struct Add-On | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR712.036 | Lumbar Spinal Fusion | _ | Moved to PA list |
| 20974 | Electrical Bone Stimulation | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.013<br>SUR705.044 | Electrical Stimulation of the Spine as an Adjunct to Spinal Fusion Procedures<br>Electrical Bone Growth Stimulation of the Appendicular Skeleton | _ | Moved to PA list |
| 20975 | Electrical Bone Stimulation | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.013<br>SUR705.044 | Electrical Stimulation of the Spine as an Adjunct to Spinal Fusion Procedures<br>Electrical Bone Growth Stimulation of the Appendicular Skeleton | _ | Moved to PA list |
| 20979 | Us Bone Stimulation | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.030 | Low Intensity Pulsed Ultrasound Fracture Healing Device | _ | _ |
| 20982 | Ablate Bone Tumor(S) Perq | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.021 | Radiofrequency Ablation (RFA) of Solid Tumors, Excluding Liver | _ | _ |
| 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). | SUR705.023 | Computer-Assisted Navigation for Orthopedic Procedures | _ | _ |
| 20999 | Musculoskeletal Surgery | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 21025 | Excision Of Bone Lower Jaw | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR705.028 | Neuralgia Inducing Cavitational Osteonecrosis (NICO) | _ | 6/30/2022 |

| | | | | | | |
|---|---|---|---|---|---|---|
| 21026 | Excision Of Facial Bone(S) | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR705.028 | Neuralgia Inducing Cavitational Osteonecrosis (NICO) | _ | 6/30/2022 |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE803.016<br>SUR705.010 | Temporomandibular Joint (TMJ) Disorders (TMJD) Manipulation Under Anesthesia | _ | _ |
| 21083 | Prepare Face/Oral Prosthesis | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR706.009 | Sleep Related Breathing Disorders: Surgical Management | _ | _ |
| 21085 | Prepare Face/Oral Prosthesis | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.030<br>SUR706.009<br>SUR705.010 | Orthognathic Surgery Temporomandibular Joint (TMJ) Disorders (TMJD) Sleep Related Breathing Disorders: Surgical Management | _ | _ |
| 21089 | Prepare Face/Oral Prosthesis | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 21120 | Reconstruction Of Chin | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001<br>SUR706.009<br>SUR705.030<br>SUR705.010<br>SUR717.001 | Orthognathic Surgery Cosmetic and Reconstructive Procedures Temporomandibular Joint (TMJ) Disorders (TMJD) Sleep Related Breathing Disorders: Surgical Management Gender Assignment Surgery and Gender Reassignment Surgery with Related Services | _ | _ |
| 21121 | Reconstruction Of Chin | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001<br>SUR706.009<br>SUR705.030<br>SUR705.010<br>SUR717.001 | Orthognathic Surgery Cosmetic and Reconstructive Procedures Temporomandibular Joint (TMJ) Disorders (TMJD) Sleep Related Breathing Disorders: Surgical Management Gender Assignment Surgery and Gender Reassignment Surgery with Related Services | _ | _ |
| 21122 | Reconstruction Of Chin | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001<br>SUR706.009<br>SUR705.030<br>SUR705.010<br>SUR717.001 | Orthognathic Surgery Cosmetic and Reconstructive Procedures Temporomandibular Joint (TMJ) Disorders (TMJD) Sleep Related Breathing Disorders: Surgical Management Gender Assignment Surgery and Gender Reassignment Surgery with Related Services | _ | _ |
| 21123 | Reconstruction Of Chin | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001<br>SUR706.009<br>SUR705.030<br>SUR705.010<br>SUR717.001 | Orthognathic Surgery Cosmetic and Reconstructive Procedures Temporomandibular Joint (TMJ) Disorders (TMJD) Sleep Related Breathing Disorders: Surgical Management Gender Assignment Surgery and Gender Reassignment Surgery with Related Services | _ | _ |
| 21125 | Augmentation Lower Jaw Bone | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.030<br>SUR717.001 | Orthognathic Surgery Gender Assignment Surgery and Gender Reassignment Surgery with Related Services | _ | _ |
| 21127 | Augmentation Lower Jaw Bone | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR706.009<br>SUR705.030<br>SUR717.001 | Orthognathic Surgery Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Sleep Related Breathing Disorders: Surgical Management | _ | _ |
| 21141 | Lefort I-1 Piece W/O Graft | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.030<br>SUR706.009<br>SUR705.010 | Orthognathic Surgery Temporomandibular Joint (TMJ) Disorders (TMJD) Sleep Related Breathing Disorders: Surgical Management | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 21142 | Lefort I-2 Piece W/O Graft | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.030 SUR706.009 SUR705.010 | Orthognathic Surgery Temporomandibular Joint (TMJ) Disorders (TMJD) Sleep Related Breathing Disorders: Surgical Management | _ | _ |
| 21143 | Lefort I-3/> Piece W/O Graft | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.030 SUR706.009 SUR705.010 | Orthognathic Surgery Temporomandibular Joint (TMJ) Disorders (TMJD) Sleep Related Breathing Disorders: Surgical Management | _ | _ |
| 21145 | Lefort I-1 Piece W/ Graft | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.030 SUR705.010 | Orthognathic Surgery Temporomandibular Joint (TMJ) Disorders (TMJD) | _ | _ |
| 21146 | Lefort I-2 Piece W/ Graft | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.030 SUR705.010 | Orthognathic Surgery Temporomandibular Joint (TMJ) Disorders (TMJD) | _ | _ |
| 21147 | Lefort I-3/> Piece W/ Graft | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.030 SUR705.010 | Orthognathic Surgery Temporomandibular Joint (TMJ) Disorders (TMJD) | _ | _ |
| 21150 | Lefort Ii Anterior Intrusion | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.030 | Orthognathic Surgery | _ | _ |
| 21151 | Lefort Ii W/Bone Grafts | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.030 | Orthognathic Surgery | _ | _ |
| 21154 | Lefort Iii W/O Lefort I | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.030 | Orthognathic Surgery | _ | _ |
| 21155 | Lefort Iii W/ Lefort I | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.030 | Orthognathic Surgery | _ | _ |
| 21159 | Lefort Iii W/Fhdw/O Lefort I | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.030 | Orthognathic Surgery | _ | _ |
| 21160 | Lefort Iii W/Fhd W/ Lefort I | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.030 | Orthognathic Surgery | _ | _ |
| 21188 | Reconstruction Of Midface | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.030 | Orthognathic Surgery | _ | _ |
| 21193 | Reconst Lwr Jaw W/O Graft | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.030 SUR706.009 SUR705.010 | Orthognathic Surgery Temporomandibular Joint (TMJ) Disorders (TMJD) Sleep Related Breathing Disorders: Surgical Management | _ | _ |
| 21194 | Reconst Lwr Jaw W/Graft | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.030 SUR706.009 SUR705.010 | Orthognathic Surgery Temporomandibular Joint (TMJ) Disorders (TMJD) Sleep Related Breathing Disorders: Surgical Management | _ | _ |
| 21195 | Reconst Lwr Jaw W/O Fixation | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.030 SUR706.009 SUR705.010 | Orthognathic Surgery Temporomandibular Joint (TMJ) Disorders (TMJD) Sleep Related Breathing Disorders: Surgical Management | _ | _ |
| 21196 | Reconst Lwr Jaw W/Fixation | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.030 SUR706.009 SUR705.010 | Orthognathic Surgery Temporomandibular Joint (TMJ) Disorders (TMJD) Sleep Related Breathing Disorders: Surgical Management | _ | _ |
| 21198 | Reconstr Lwr Jaw Segment | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.030 SUR706.009 SUR705.010 | Orthognathic Surgery Temporomandibular Joint (TMJ) Disorders (TMJD) Sleep Related Breathing Disorders: Surgical Management | _ | _ |
| 21199 | Reconstr Lwr Jaw W/Advance | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.030 SUR706.009 SUR705.010 | Orthognathic Surgery Temporomandibular Joint (TMJ) Disorders (TMJD) Sleep Related Breathing Disorders: Surgical Management | _ | _ |
| 21206 | Reconstruct Upper Jaw Bone | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.030 | Orthognathic Surgery | _ | _ |
| 21208 | Augmentation Of Facial Bones | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.030 | Orthognathic Surgery | _ | _ |
| 21209 | Reduction Of Facial Bones | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.030 | Orthognathic Surgery | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 21210 | Face Bone Graft | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.028 SUR706.009 SUR705.030 | Orthognathic Surgery Sleep Related Breathing Disorders: Surgical Management Neuralgia Inducing Cavitational Osteonecrosis (NICO) | _ | _ |
| 21215 | Lower Jaw Bone Graft | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.028 SUR706.009 SUR705.030 | Orthognathic Surgery Sleep Related Breathing Disorders: Surgical Management Neuralgia Inducing Cavitational Osteonecrosis (NICO) | _ | _ |
| 21244 | Reconstruction Of Lower Jaw | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR706.009 | Sleep Related Breathing Disorders: Surgical Management | _ | _ |
| 21245 | Reconstruction Of Jaw | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR706.009 | Sleep Related Breathing Disorders: Surgical Management | _ | _ |
| 21246 | Reconstruction Of Jaw | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR706.009 | Sleep Related Breathing Disorders: Surgical Management | _ | _ |
| 21247 | Reconstruct Lower Jaw Bone | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | _ | _ |
| 21248 | Reconstruction Of Jaw | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | _ | _ |
| 21249 | Reconstruction Of Jaw | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | _ | _ |
| 21299 | Cranio/Maxillofacial Surgery | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 21499 | Head Surgery Procedure | 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR706.009 | Sleep Related Breathing Disorders: Surgical Management | _ | _ |
| 21740 | Reconstruction Of Sternum | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001 | Cosmetic and Reconstructive Procedures | _ | _ |
| 21742 | Repair Stern/Nuss W/O Scope | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001 | Cosmetic and Reconstructive Procedures | _ | _ |
| 21743 | Repair Sternum/Nuss W/Scope | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001 | Cosmetic and Reconstructive Procedures | _ | _ |
| 21899 | Neck/Chest Surgery Procedure | 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE803.016 | Manipulation Under Anesthesia | _ | _ |
| 22510 | Perq Cervicothoracic Inject | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RAD601.056 | Percutaneous Vertebroplasty and Sacroplasty | _ | Moved to PA list |
| 22511 | Perq Lumbosacral Injection | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RAD601.056 | Percutaneous Vertebroplasty and Sacroplasty | _ | Moved to PA list |
| 22512 | Vertebroplasty Addl Inject | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RAD601.056 | Percutaneous Vertebroplasty and Sacroplasty | _ | Moved to PA list |
| 22513 | Perq Vertebral Augmentation | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RAD601.041 | Percutaneous Balloon Kyphoplasty, Radiofrequency Kyphoplasty, and Mechanical Vertebral Augmentation | _ | Moved to PA list |
| 22514 | Perq Vertebral Augmentation | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RAD601.041 | Percutaneous Balloon Kyphoplasty, Radiofrequency Kyphoplasty, and Mechanical Vertebral Augmentation | _ | Moved to PA list |
| 22515 | Perq Vertebral Augmentation | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RAD601.041 | Percutaneous Balloon Kyphoplasty, Radiofrequency Kyphoplasty, and Mechanical Vertebral Augmentation | _ | Moved to PA list |

| | | | | | | |
|---|---|---|---|---|---|---|
| 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). | SUR712.023 | Percutaneous Intradiscal Electrothermal Annuloplasty, Radiofrequency Annuloplasty, and Biacuplasty | 1/1/2023 | _ |
| 22526 | Idet Single Level | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR712.023 | Percutaneous Intradiscal Electrothermal Annuloplasty, Radiofrequency Annuloplasty, and Biacuplasty | _ | Moved to PA list |
| 22526 | Idet Single Level | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR712.023 | Percutaneous Intradiscal Electrothermal Annuloplasty, Radiofrequency Annuloplasty, and Biacuplasty | 10/1/2022 | 12/31/2022 |
| 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). | SUR712.023 | Percutaneous Intradiscal Electrothermal Annuloplasty, Radiofrequency Annuloplasty, and Biacuplasty | 1/1/2023 | _ |
| 22527 | Idet 1 Or More Levels | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR712.023 | Percutaneous Intradiscal Electrothermal Annuloplasty, Radiofrequency Annuloplasty, and Biacuplasty | _ | Moved to PA list |
| 22527 | Idet 1 Or More Levels | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR712.023 | Percutaneous Intradiscal Electrothermal Annuloplasty, Radiofrequency Annuloplasty, and Biacuplasty | 10/1/2022 | 12/31/2022 |
| 22533 | Lat Lumbar Spine Fusion | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR712.036 | Lumbar Spinal Fusion | _ | Moved to PA list |
| 22534 | Lat Thor/Lumb Addl Seg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR712.036 | Lumbar Spinal Fusion | _ | Moved to PA list |
| 22558 | Lumbar Spine Fusion | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR712.036 | Lumbar Spinal Fusion | _ | Moved to PA list |
| 22585 | Additional Spinal Fusion | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR712.036 | Lumbar Spinal Fusion | _ | Moved to PA list |
| 22586 | Prescrl Fuse W/ Instr L5-S1 | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR712.038 | Axial Lumbosacral Interbody Fusion | _ | _ |
| 22610 | Thorax Spine Fusion | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 22612 | Lumbar Spine Fusion | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR712.036 | Lumbar Spinal Fusion | _ | Moved to PA list |
| 22614 | Spine Fusion Extra Segment | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR712.036 | Lumbar Spinal Fusion | _ | Moved to PA list |
| 22630 | Lumbar Spine Fusion | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR712.036 | Lumbar Spinal Fusion | _ | Moved to PA list |
| 22632 | Spine Fusion Extra Segment | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR712.036 | Lumbar Spinal Fusion | _ | Moved to PA list |
| 22633 | Lumbar Spine Fusion Combined | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR712.036 | Lumbar Spinal Fusion | _ | Moved to PA list |
| 22634 | Spine Fusion Extra Segment | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR712.036 | Lumbar Spinal Fusion | _ | Moved to PA list |
| 22800 | Post Fusion </6 Vert Seg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR712.036 | Lumbar Spinal Fusion | _ | Moved to PA list |
| 22802 | Post Fusion 7-12 Vert Seg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR712.036 | Lumbar Spinal Fusion | _ | Moved to PA list |
| 22804 | Post Fusion 13/> Vert Seg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR712.036 | Lumbar Spinal Fusion | _ | Moved to PA list |
| 22808 | Ant Fusion 2-3 Vert Seg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR712.036 | Lumbar Spinal Fusion | _ | Moved to PA list |
| 22810 | Ant Fusion 4-7 Vert Seg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR712.036 | Lumbar Spinal Fusion | _ | Moved to PA list |
| 22812 | Ant Fusion 8/> Vert Seg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR712.036 | Lumbar Spinal Fusion | _ | Moved to PA list |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 22840 | | | | Cervical Spinal Fusion | | | |
| | | Medical Policy Criteria: Procedure/service may require prior authorization. | SUR712.041 | Lumbar Spinal Fusion | | | |
| | | Refer to prior authorization resources available on the provider section of the | SUR712.036 | Interspinous Fixation | | | |
| | Insert Spine Fixation Device | BCBSOK website. | SUR712.040 | (Fusion) Devices | _ | | Moved to PA list |
| 22841 | | Medical Policy Criteria: Procedure/service may require prior authorization. | | | | | |
| | | Refer to prior authorization resources available on the provider section of the | SUR712.041 | Lumbar Spinal Fusion | | | |
| | Insert Spine Fixation Device | BCBSOK website. | SUR712.036 | Cervical Spinal Fusion | _ | | Moved to PA list |
| 22842 | | Medical Policy Criteria: Procedure/service may require prior authorization. | | | | | |
| | | Refer to prior authorization resources available on the provider section of the | SUR712.041 | Lumbar Spinal Fusion | | | |
| | Insert Spine Fixation Device | BCBSOK website. | SUR712.036 | Cervical Spinal Fusion | _ | | Moved to PA list |
| 22843 | | Medical Policy Criteria: Procedure/service may require prior authorization. | | | | | |
| | | Refer to prior authorization resources available on the provider section of the | SUR712.041 | Lumbar Spinal Fusion | | | |
| | Insert Spine Fixation Device | BCBSOK website. | SUR712.036 | Cervical Spinal Fusion | _ | | Moved to PA list |
| 22844 | | Medical Policy Criteria: Procedure/service may require prior authorization. | | | | | |
| | | Refer to prior authorization resources available on the provider section of the | SUR712.041 | Lumbar Spinal Fusion | | | |
| | Insert Spine Fixation Device | BCBSOK website. | SUR712.036 | Cervical Spinal Fusion | _ | | Moved to PA list |
| 22845 | | Medical Policy Criteria: Procedure/service may require prior authorization. | | | | | |
| | | Refer to prior authorization resources available on the provider section of the | SUR712.041 | Lumbar Spinal Fusion | | | |
| | Insert Spine Fixation Device | BCBSOK website. | SUR712.036 | Cervical Spinal Fusion | _ | | Moved to PA list |
| 22846 | | Medical Policy Criteria: Procedure/service may require prior authorization. | | | | | |
| | | Refer to prior authorization resources available on the provider section of the | SUR712.041 | Lumbar Spinal Fusion | | | |
| | Insert Spine Fixation Device | BCBSOK website. | SUR712.036 | Cervical Spinal Fusion | _ | | Moved to PA list |
| 22847 | | Medical Policy Criteria: Procedure/service may require prior authorization. | | | | | |
| | | Refer to prior authorization resources available on the provider section of the | SUR712.041 | Lumbar Spinal Fusion | | | |
| | Insert Spine Fixation Device | BCBSOK website. | SUR712.036 | Cervical Spinal Fusion | _ | | Moved to PA list |
| 22848 | | Medical Policy Criteria: Procedure/service may require prior authorization. | | | | | |
| | | Refer to prior authorization resources available on the provider section of the | | | | | |
| | Insert Pelv Fixation Device | BCBSOK website. | SUR712.036 | Lumbar Spinal Fusion | _ | | Moved to PA list |
| 22853 | | | | Cervical Spinal Fusion | | | |
| | | Medical Policy Criteria: Procedure/service may require prior authorization. | SUR712.041 | Lumbar Spinal Fusion | | | |
| | | Refer to prior authorization resources available on the provider section of the | SUR712.036 | Interspinous Fixation | | | |
| | Insj Biomechanical Device | BCBSOK website. | SUR712.040 | (Fusion) Devices | _ | | Moved to PA list |
| 22854 | | | | Cervical Spinal Fusion | | | |
| | | Medical Policy Criteria: Procedure/service may require prior authorization. | SUR712.041 | Lumbar Spinal Fusion | | | |
| | | Refer to prior authorization resources available on the provider section of the | SUR712.036 | Interspinous Fixation | | | |
| | Insj Biomechanical Device | BCBSOK website. | SUR712.040 | (Fusion) Devices | _ | | Moved to PA list |
| 22856 | | Medical Policy Criteria: Procedure/service may require prior authorization. | | | | | |
| | | Refer to prior authorization resources available on the provider section of the | | | | | |
| | Cerv Artific Diskectomy | BCBSOK website. | SUR712.028 | Artificial Intervertebral Disc | _ | | Moved to PA list |
| 22857 | | Medical Policy Criteria: Procedure/service may require prior authorization. | | | | | |
| | | Refer to prior authorization resources available on the provider section of the | | | | | |
| | Lumbar Artif Diskectomy | BCBSOK website. | SUR712.028 | Artificial Intervertebral Disc | _ | | Moved to PA list |
| 22858 | | Medical Policy Criteria: Procedure/service may require prior authorization. | | | | | |
| | | Refer to prior authorization resources available on the provider section of the | | | | | |
| | Second Level Cer Diskectomy | BCBSOK website. | SUR712.028 | Artificial Intervertebral Disc | _ | | Moved to PA list |
| 22859 | | | | Cervical Spinal Fusion | | | |
| | | Medical Policy Criteria: Procedure/service may require prior authorization. | SUR712.041 | Lumbar Spinal Fusion | | | |
| | | Refer to prior authorization resources available on the provider section of the | SUR712.036 | Interspinous Fixation | | | |
| | Insj Biomechanical Device | BCBSOK website. | SUR712.040 | (Fusion) Devices | _ | | Moved to PA list |
| 22862 | | Medical Policy Criteria: Procedure/service may require prior authorization. | | | | | |
| | | Refer to prior authorization resources available on the provider section of the | | | | | |
| | Revise Lumbar Artif Disc | BCBSOK website. | SUR712.028 | Artificial Intervertebral Disc | _ | | Moved to PA list |
| 22865 | | Medical Policy Criteria: Procedure/service may require prior authorization. | | | | | |
| | | Refer to prior authorization resources available on the provider section of the | | | | | |
| | Remove Lumb Artif Disc | BCBSOK website. | SUR712.028 | Artificial Intervertebral Disc | _ | | Moved to PA list |
| 22867 | | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization | | Interspinous Distraction | | | |
| | | review. Please see the Clinical Payment and Coding Policy titled: Non- | | (Spacers) and Interlaminar | | | |
| | Insj Stablj Dev W/Dcmprn | Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR712.029 | Stabilization Devices | 1/1/2023 | _ | |
| 22867 | | Medical Policy Criteria: Procedure/service may require prior authorization. | | Interspinous Distraction | | | |
| | | Refer to prior authorization resources available on the provider section of the | | (Spacers) and Interlaminar | | | |
| | Insj Stablj Dev W/Dcmprn | BCBSOK website. | SUR712.029 | Stabilization Devices | _ | | Moved to PA list |
| 22867 | | Medical Policy Criteria: Procedure/service reviewed to ensure each service | | | | | |
| | | meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a | | Interspinous Distraction | | | |
| | | predetermination request if it is unclear if the service meets BCBSOK Medical | | (Spacers) and Interlaminar | | | |
| | Insj Stablj Dev W/Dcmprn | Policy criteria. | SUR712.029 | Stabilization Devices | 10/1/2022 | | 12/31/2022 |
| 22868 | | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization | | Interspinous Distraction | | | |
| | | review. Please see the Clinical Payment and Coding Policy titled: Non- | | (Spacers) and Interlaminar | | | |
| | Insj Stablj Dev W/Dcmprn | Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR712.029 | Stabilization Devices | 1/1/2023 | _ | |
| 22868 | | Medical Policy Criteria: Procedure/service may require prior authorization. | | Interspinous Distraction | | | |
| | | Refer to prior authorization resources available on the provider section of the | | (Spacers) and Interlaminar | | | |
| | Insj Stablj Dev W/Dcmprn | BCBSOK website. | SUR712.029 | Stabilization Devices | _ | | Moved to PA list |
| 22868 | | Medical Policy Criteria: Procedure/service reviewed to ensure each service | | | | | |
| | | meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a | | Interspinous Distraction | | | |
| | | predetermination request if it is unclear if the service meets BCBSOK Medical | | (Spacers) and Interlaminar | | | |
| | Insj Stablj Dev W/Dcmprn | Policy criteria. | SUR712.029 | Stabilization Devices | 10/1/2022 | | 12/31/2022 |
| 22869 | | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization | | Interspinous Distraction | | | |
| | | review. Please see the Clinical Payment and Coding Policy titled: Non- | | (Spacers) and Interlaminar | | | |
| | Insj Stablj Dev W/O Dcmprn | Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR712.029 | Stabilization Devices | 1/1/2023 | _ | |
| 22869 | | Medical Policy Criteria: Procedure/service may require prior authorization. | | Interspinous Distraction | | | |
| | | Refer to prior authorization resources available on the provider section of the | | (Spacers) and Interlaminar | | | |
| | Insj Stablj Dev W/O Dcmprn | BCBSOK website. | SUR712.029 | Stabilization Devices | _ | | Moved to PA list |
| 22869 | | Medical Policy Criteria: Procedure/service reviewed to ensure each service | | | | | |
| | | meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a | | Interspinous Distraction | | | |
| | | predetermination request if it is unclear if the service meets BCBSOK Medical | | (Spacers) and Interlaminar | | | |
| | Insj Stablj Dev W/O Dcmprn | Policy criteria. | SUR712.029 | Stabilization Devices | 10/1/2022 | | 12/31/2022 |
| 22870 | | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization | | Interspinous Distraction | | | |
| | | review. Please see the Clinical Payment and Coding Policy titled: Non- | | (Spacers) and Interlaminar | | | |
| | Insj Stablj Dev W/O Dcmprn | Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR712.029 | Stabilization Devices | 1/1/2023 | _ | |
| 22870 | | Medical Policy Criteria: Procedure/service may require prior authorization. | | Interspinous Distraction | | | |
| | | Refer to prior authorization resources available on the provider section of the | | (Spacers) and Interlaminar | | | |
| | Insj Stablj Dev W/O Dcmprn | BCBSOK website. | SUR712.029 | Stabilization Devices | _ | | Moved to PA list |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 22870 | Insj Stablj Dev W/O Dcmprn | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR712.029 | Interspinous Distraction (Spacers) and Interlaminar Stabilization Devices | _ | 10/1/2022 | 12/31/2022 |
| 22899 | Spine Surgery Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | | _ |
| 22999 | Abdomen Surgery Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | | _ |
| 23470 | Reconstruct Shoulder Joint | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.032 | Shoulder Resurfacing | _ | | Moved to PA list |
| 23472 | Reconstruct Shoulder Joint | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.032 | Shoulder Resurfacing | _ | | Moved to PA list |
| 23929 | Shoulder Surgery Procedure | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR705.032 | Shoulder Resurfacing | _ | | _ |
| 24300 | Manipulate Elbow W/Anesth | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE803.016 | Manipulation Under Anesthesia | _ | | _ |
| 24999 | Upper Arm/Elbow Surgery | 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE803.016 | Manipulation Under Anesthesia | _ | | _ |
| 25999 | Forearm Or Wrist Surgery | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | | _ |
| 26340 | Manipulate Finger W/Anesth | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE803.016 | Manipulation Under Anesthesia | _ | | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.073 | Clostridial Collagenase for Fibroproliferative Disorders | _ | | _ |
| 26989 | Hand/Finger Surgery | 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | _ | | _ |
| 27275 | Manipulation Of Hip Joint | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE803.016 | Manipulation Under Anesthesia | _ | | _ |
| 27279 | Arthrodesis Sacroiliac Joint | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.033 | Sacroiliac Joint Fusion or Stabilization | _ | | Moved to PA list |
| 27280 | Fusion Of Sacroiliac Joint | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.033 | Sacroiliac Joint Fusion or Stabilization | _ | | Moved to PA list |
| 27280 | Fusion Of Sacroiliac Joint | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR705.033 | Sacroiliac Joint Fusion or Stabilization | _ | 10/1/2022 | _ |
| 27299 | Pelvis/Hip Joint Surgery | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. May require Prior Authorization based on contract agreement until 03/31/2022. | _ | _ | _ | | _ |
| 27412 | Autochondrocyte Implant Knee | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.035 | Autologous Chondrocyte Implantation (ACI) for Focal Articular Cartilage Lesions | _ | | Moved to PA list |
| 27415 | Osteochondral Knee Allograft | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.020 | Autografts and Allografts in the Treatment of Focal Articular Cartilage Lesions | _ | | Moved to PA list |
| 27416 | Osteochondral Knee Autograft | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.020 | Autografts and Allografts in the Treatment of Focal Articular Cartilage Lesions | _ | | Moved to PA list |
| 27599 | Leg Surgery Procedure | 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR705.021 | Total Ankle Replacement (TAR) | _ | | _ |
| 27703 | Reconstruction Ankle Joint | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR705.021 | Total Ankle Replacement (TAR) | _ | | _ |
| 27704 | Removal Of Ankle Implant | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR705.021 | Total Ankle Replacement (TAR) | _ | | _ |
| 27860 | Fixation Of Ankle Joint | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE803.016 | Manipulation Under Anesthesia | _ | | _ |
| 27899 | Leg/Ankle Surgery Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 28446 | Osteochondral Talus Autogrft | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.020 | Autografts and Allografts in the Treatment of Focal Articular Cartilage Lesions | _ | Moved to PA list |
| 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). | SUR705.018 | Extracorporeal Shock Wave Therapy for Musculoskeletal Indications and Soft Tissue Injuries | _ | _ |
| 28899 | Foot/Toes Surgery Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 29799 | Casting/Strapping Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 29862 | Hip Arthr0 W/Debridement | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR705.029 | Surgical Treatment of Femoroacetabular Impingement (FAI) | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR705.020<br>SUR705.035 | Autologous Chondrocyte Implantation (ACI) for Focal Articular Cartilage Lesions<br>Autografts and Allografts in the Treatment of Focal Articular Cartilage Lesions | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR705.020 | Autografts and Allografts in the Treatment of Focal Articular Cartilage Lesions | _ | _ |
| 29868 | Meniscal Trnspl Knee W/Scpe | [illegible] meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a | SUR705.034 | Other Meniscal Implants | _ | _ |
| 29914 | Hip Arthro W/Femoroplasty | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR705.029 | Surgical Treatment of Femoroacetabular Impingement (FAI) | _ | _ |
| 29915 | Hip Arthro Acetabuloplasty | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR705.029 | Surgical Treatment of Femoroacetabular Impingement (FAI) | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR705.029 | Surgical Treatment of Femoroacetabular Impingement (FAI) | _ | _ |
| 29999 | Arthroscopy Of Joint | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR705.024<br>SUR705.029<br>SUR705.041 | Unicondylar Interpositional Spacer as a Treatment of Unicompartmental Arthritis of the Knee<br>Surgical Treatment of Femoroacetabular Impingement (FAI)<br>Thermal Capsulorrhaphy as a Treatment of Joint Instability | _ | _ |
| 30120 | Revision Of Nose | [illegible] Refer to prior authorization resources available on the provider section of the | THE801.030 | [illegible] Treatment of Rosacea | _ | _ |
| 30400 | Reconstruction Of Nose | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR706.001<br>SUR717.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Nasal and Sinus Surgery | _ | 10/31/2022 |
| 30410 | Reconstruction Of Nose | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR706.001<br>SUR717.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Nasal and Sinus Surgery | _ | 10/31/2022 |
| 30420 | Reconstruction Of Nose | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR706.001<br>SUR717.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Nasal and Sinus Surgery | _ | 10/31/2022 |
| 30430 | Revision Of Nose | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR706.001<br>SUR717.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Nasal and Sinus Surgery | _ | 10/31/2022 |
| 30435 | Revision Of Nose | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR706.001<br>SUR717.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Nasal and Sinus Surgery | _ | 10/31/2022 |
| 30450 | Revision Of Nose | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR706.001<br>SUR717.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Nasal and Sinus Surgery | _ | 10/31/2022 |
| 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). | SUR706.017 | Absorbable Nasal Implant for Treatment of Nasal Valve Collapse | 5/15/2021 | _ |
| 30999 | Nasal Surgery Procedure | [illegible] and may be subject to benefit and/or clinical review. May require Prior | SUR706.001 | Nasal and Sinus Surgery | _ | _ |
| 31295 | Nsl/Sins Ndsc Surg Max Sins | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR706.019 | Balloon Ostial Dilation for Treatment of Chronic and Recurrent Acute Rhinosinusitis | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 31296 | Nsl/Sins Ndsc Surg Frnt Sins | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR706.019 | Balloon Ostial Dilation for Treatment of Chronic and Recurrent Acute Rhinosinusitis | _ | _ |
| 31297 | Nsl/Sins Ndsc Surg Sphn Sins | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR706.019 | Balloon Ostial Dilation for Treatment of Chronic and Recurrent Acute Rhinosinusitis | _ | _ |
| 31298 | Nsl/Sins Ndsc Surg Frnt&Sphn | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR706.019 | Balloon Ostial Dilation for Treatment of Chronic and Recurrent Acute Rhinosinusitis | _ | _ |
| 31299 | Sinus Surgery Procedure | and may be subject to benefit and/or clinical review. May require Prior | SUR706.019 | Balloon Ostial Dilation for | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001 | Cosmetic and Reconstructive Procedures | _ | _ |
| 31573 | Largsc W/Ther Injection | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001 | Cosmetic and Reconstructive Procedures | _ | _ |
| 31574 | Largsc W/Njx Augmentation | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001 | Cosmetic and Reconstructive Procedures | _ | _ |
| 31599 | Larynx Surgery Procedure | 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR706.013 | Electromagnetic Navigation Bronchoscopy (ENB) | _ | _ |
| 31634 | Bronch W/Balloon Occlusion | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.014 | Endoscopic, Arthroscopic, Laparoscopic, Bronchoscopic and Thoracoscopic Surgery | _ | _ |
| 31647 | Bronchial Valve Init Insert | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR706.015 | Bronchial Valves | _ | _ |
| 31648 | Bronchial Valve Remov Init | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR706.015 | Bronchial Valves | _ | _ |
| 31649 | Bronchial Valve Remov Addl | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR706.015 | Bronchial Valves | _ | _ |
| 31651 | Bronchial Valve Addl Insert | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR706.015 | Bronchial Valves | _ | _ |
| 31660 | Bronch Thermoplsty 1 Lobe | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR706.014 | Bronchial Thermoplasty | _ | _ |
| 31661 | Bronch Thermoplsty 2/> Lobes | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR706.014 | Bronchial Thermoplasty | _ | _ |
| 31899 | Airways Surgical Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 32553 | Ins Mark Thor For Rt Perq | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | _ | _ |
| 32664 | Thoracoscopy W/ Th Nrv Exc | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.014 | Treatment of Hyperhidrosis | _ | _ |
| 32701 | Thorax Stereo Rad Targetw/Tx | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 32994 | Ablate Pulm Tumor Perq Crybl | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.018 | Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors | _ | _ |
| 32998 | Ablate Pulm Tumor Perq Rf | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.038 SUR701.021 | Microwave Tumor Ablation Radiofrequency Ablation (RFA) of Solid Tumors, Excluding Liver | _ | _ |
| 32999 | Chest Surgery Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 33211 | Insert Card Electrodes Dual | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.054 | Biventricular Pacemakers (Cardiac Resynchronization Therapy) for the Treatment of Heart Failure | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 33213 | Insert Pulse Gen Dual Leads | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.054 | Biventricular Pacemakers (Cardiac Resynchronization Therapy) for the Treatment of Heart Failure | _ | _ |
| 33225 | L Ventric Pacing Lead Add-On | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.054 | Biventricular Pacemakers (Cardiac Resynchronization Therapy) for the Treatment of Heart Failure | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.009 | Percutaneous and Surgical Closure of the Left Atrial Appendage for Stroke Prevention in Atrial Fibrillation | 10/1/2022 | _ |
| 33268 | EXCL LAA OTH PX ANY METH | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.009 | Percutaneous and Surgical Closure of the Left Atrial Appendage for Stroke Prevention in Atrial Fibrillation | 10/1/2022 | _ |
| 33269 | EXCL LAA THRSCP ANY METHOD | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.009 | Percutaneous and Surgical Closure of the Left Atrial Appendage for Stroke Prevention in Atrial Fibrillation | 10/1/2022 | _ |
| 33270 | Ins/Rep Subq Defibrillator | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.003 | Implantable Cardioverter Defibrillators | _ | _ |
| 33271 | Insj Subq Impltbl Dfb Elctrd | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.003 | Implantable Cardioverter Defibrillators | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.030 | Leadless Cardiac Pacemaker | _ | _ |
| 33275 | Tcat Rmvl Perm Ldls Pm W/Img | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.030 | Leadless Cardiac Pacemaker | _ | _ |
| 33285 | Insj Subq Car Rhythm Mntr | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.003 | Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems) | _ | _ |
| 33289 | Tcat Impl Wrls P-Art Prs Snr | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.058 | Cardiac Hemodynamic Monitoring for the Management of Heart Failure in the Outpatient Setting | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.009 | Percutaneous and Surgical Closure of the Left Atrial Appendage for Stroke Prevention in Atrial Fibrillation | _ | _ |
| 33361 | Replace Aortic Valve Perq | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.028 | Transcatheter Aortic-Valve Implantation for Aortic Stenosis | _ | _ |
| 33362 | Replace Aortic Valve Open | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.028 | Transcatheter Aortic-Valve Implantation for Aortic Stenosis | _ | _ |
| 33363 | Replace Aortic Valve Open | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.028 | Transcatheter Aortic-Valve Implantation for Aortic Stenosis | _ | _ |
| 33364 | Replace Aortic Valve Open | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.028 | Transcatheter Aortic-Valve Implantation for Aortic Stenosis | _ | _ |
| 33365 | Replace Aortic Valve Open | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.028 | Transcatheter Aortic-Valve Implantation for Aortic Stenosis | _ | _ |
| 33366 | Trcath Replace Aortic Valve | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.028 | Transcatheter Aortic-Valve Implantation for Aortic Stenosis | _ | _ |
| 33367 | Replace Aortic Valve W/Byp | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.028 | Transcatheter Aortic-Valve Implantation for Aortic Stenosis | _ | _ |
| 33368 | Replace Aortic Valve W/Byp | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.028 | Transcatheter Aortic-Valve Implantation for Aortic Stenosis | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 33369 | Replace Aortic Valve W/Byp | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.028 | Transcatheter Aortic-Valve Implantation for Aortic Stenosis | _ | _ |
| 33418 | Repair Tcat Mitral Valve | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.025 | Transcatheter Mitral Valve Procedures | _ | _ |
| 33419 | Repair Tcat Mitral Valve | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.025 | Transcatheter Mitral Valve Procedures | _ | _ |
| 33477 | Implant Tcat Pulm Vlv Perq | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.029 | Transcatheter Pulmonary Valve Implantation | _ | _ |
| 33542 | Removal Of Heart Lesion | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.026 | Cardiac Restoration and Remodeling Procedures | _ | _ |
| 33880 | Endovasc Taa Repr Incl Subcl | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.057 | Endovascular Stent Grafts for Disorders of the Thoracic Aorta | _ | _ |
| 33881 | Endovasc Taa Repr W/O Subcl | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.057 | Endovascular Stent Grafts for Disorders of the Thoracic Aorta | _ | _ |
| 33883 | Insert Endovasc Prosth Taa | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.057 | Endovascular Stent Grafts for Disorders of the Thoracic Aorta | _ | _ |
| 33884 | Endovasc Prosth Taa Add-On | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.057 | Endovascular Stent Grafts for Disorders of the Thoracic Aorta | _ | _ |
| 33886 | Endovasc Prosth Delayed | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.057 | Endovascular Stent Grafts for Disorders of the Thoracic Aorta | _ | _ |
| 33889 | Artery Transpose/Endovas Taa | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.057 | Endovascular Stent Grafts for Disorders of the Thoracic Aorta | _ | _ |
| 33891 | Car-Car Bp Grft/Endovas Taa | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | _ | _ | _ | 8/31/2022 |
| 33927 | Impltj Tot Rplcmt Hrt Sys | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| 33928 | Rmvl & Rplcmt Tot Hrt Sys | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| 33929 | Rmvl Rplcmt Hrt Sys F/Trnspl | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| 33975 | Implant Ventricular Device | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| 33976 | Implant Ventricular Device | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| 33979 | Insert Intracorporeal Device | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| 33981 | Replace Vad Pump Ext | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| 33982 | Replace Vad Intra W/O Bp | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| 33983 | Replace Vad Intra W/Bp | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| 33990 | Insj Perq Vad L Hrt Arterial | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 33991 | Insj Perq Vad L Hrt Artl&Ven | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| 33992 | Rmvl Perq Left Heart Vad | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| 33993 | Reposg Perq R/L Hrt Vad | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| 33999 | Cardiac Surgery Procedure | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR703.027<br>SUR707.026<br>SUR701.009 | Stem-Cell Therapy for the Treatment of Damaged Myocardium Due to Ischemia<br>Cardiac Restoration and Remodeling Procedures<br>Percutaneous and Surgical Closure of the Left Atrial Appendage for Stroke Prevention in Atrial Fibrillation | _ | _ |
| 36260 | Insertion Of Infusion Pump | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.008 | Implantable Infusion Pump for Pain and Spasticity | _ | _ |
| 36299 | Vessel Injection Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 36465 | Njx Noncmpnd Sclrsnt 1 Vein | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.016 | Varicose Vein Management | _ | _ |
| 36466 | Njx Noncmpnd Sclrsnt Mlt Vn | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.016 | Varicose Vein Management | _ | _ |
| 36468 | Njx Sclrsnt Spider Veins | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.016 | Varicose Vein Management | _ | _ |
| 36470 | Njx Sclrsnt 1 Incmptnt Vein | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.016 | Varicose Vein Management | _ | _ |
| 36471 | Njx Sclrsnt Mlt Incmptnt Vn | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.016 | Varicose Vein Management | _ | _ |
| 36473 | Endovenous Mchnchem 1St Vein | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR707.016 | Varicose Vein Management | _ | _ |
| 36474 | Endovenous Mchnchem Add-On | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR707.016 | Varicose Vein Management | _ | _ |
| 36475 | Endovenous Rf 1St Vein | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.016 | Varicose Vein Management | _ | _ |
| 36476 | Endovenous Rf Vein Add-On | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.016 | Varicose Vein Management | _ | _ |
| 36478 | Endovenous Laser 1St Vein | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.016 | Varicose Vein Management | _ | _ |
| 36479 | Endovenous Laser Vein Addon | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.016 | Varicose Vein Management | _ | _ |
| 36482 | Endoven Ther Chem Adhes 1St | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.016 | Varicose Vein Management | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 36483 | Endoven Ther Chem Adhes Sbsq | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.016 | Varicose Vein Management | _ | _ |
| 36511 | Apheresis Wbc | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR703.042<br>SUR703.030<br>SUR703.033<br>SUR703.037<br>SUR703.038<br>SUR703.034<br>SUR703.046<br>SUR703.050<br>SUR703.041<br>SUR703.047<br>SUR703.036<br>SUR703.029<br>SUR703.032<br>SUR703.031<br>SUR703.043<br>SUR703.045<br>SUR703.035<br>SUR703.040<br>SUR703.002<br>THE801.024<br>SUR703.044<br>SUR703.039 | Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)<br>Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors<br>Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas<br>Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML)<br>Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML)<br>Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer<br>Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma<br>Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL)<br>Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information)<br>Hematopoietic Cell | _ | _ |
| 36516 | Apheresis Immunoads Slctv | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | THE802.003 | Lipid Apheresis | _ | _ |
| 36522 | Photopheresis | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE801.026 | Extracorporeal Photopheresis (ECP) | _ | _ |
| 36563 | Insert Tunneled Cv Cath | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.008 | Implantable Infusion Pump for Pain and Spasticity | _ | _ |
| 37215 | Transcath Stent Cca W/Eps | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.028 | Extracranial Carotid Angioplasty or Stenting | _ | _ |
| 37216 | Transcath Stent Cca W/O Eps | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.028 | Extracranial Carotid Angioplasty or Stenting | _ | _ |
| 37217 | Stent Placemt Retro Carotid | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.028 | Extracranial Carotid Angioplasty or Stenting | _ | _ |
| 37218 | Stent Placemt Ante Carotid | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.028 | Extracranial Carotid Angioplasty or Stenting | _ | _ |
| 37241 | Vasc Embolize/Occlude Venous | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.015 | Therapeutic Embolization and Vessel Occlusion to Treat Pelvic Conditions | _ | _ |
| 37242 | Vasc Embolize/Occlude Artery | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.015 | Therapeutic Embolization and Vessel Occlusion to Treat Pelvic Conditions | _ | _ |
| 37243 | Vasc Embolize/Occlude Organ | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RAD601.047<br>SUR701.015<br>THE801.022 | Radioembolization for Primary and Metastatic Tumors of the Liver<br>Therapeutic Embolization and Vessel Occlusion to Treat Pelvic Conditions<br>Transcatheter Arterial Chemoembolization (TACE) of the Liver | _ | _ |
| 37244 | Vasc Embolize/Occlude Bleed | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.015 | Therapeutic Embolization and Vessel Occlusion to Treat Pelvic Conditions | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 37500 | Endoscopy Ligate Perf Veins | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.016 | Varicose Vein Management | _ | _ |
| 37501 | Vascular Endoscopy Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 37700 | Revise Leg Vein | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.016 | Varicose Vein Management | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 37718 | Ligate/Strip Short Leg Vein | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.016 | Varicose Vein Management _ | _ | |
| 37722 | Ligate/Strip Long Leg Vein | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.016 | Varicose Vein Management _ | _ | |
| 37735 | Removal Of Leg Veins/Lesion | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.016 | Varicose Vein Management _ | _ | |
| 37760 | Ligate Leg Veins Radical | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.016 | Varicose Vein Management _ | _ | |
| 37761 | Ligate Leg Veins Open | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.016 | Varicose Vein Management _ | _ | |

| | | | | | | |
|---|---|---|---|---|---|---|
| 37765 | Stab Phleb Veins Xtr 10-20 | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.016 | Varicose Vein Management | _ | _ |
| 37766 | Phleb Veins - Extrem 20+ | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.016 | Varicose Vein Management | _ | _ |
| 37780 | Revision Of Leg Vein | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.016 | Varicose Vein Management | _ | _ |
| 37785 | Ligate/Divide/Excise Vein | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.016 | Varicose Vein Management | _ | _ |
| 37788 | Revascularization Penis | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.030 | Sexual Dysfunctions, Assessment and Treatment | _ | _ |
| 37790 | Penile Venous Occlusion | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.030 | Sexual Dysfunctions, Assessment and Treatment | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 37799 | Vascular Surgery Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 38129 | Laparoscope Proc Spleen | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 38204 | Bl Donor Search Management | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR703.042<br>SUR703.033<br>SUR703.030<br>SUR703.037<br>SUR703.038<br>SUR703.034<br>SUR703.046<br>SUR703.050<br>SUR703.041<br>SUR703.036<br>SUR703.047<br>SUR703.029<br>SUR703.032<br>SUR703.031<br>SUR703.043<br>SUR703.045<br>SUR703.035<br>SUR703.040<br>SUR703.002<br>SUR703.044<br>SUR703.039 | Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)<br>Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors<br>Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas<br>Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML)<br>Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML)<br>Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer<br>Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma<br>Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL)<br>Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information)<br>Hematopoietic Cell | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 38205 | | | | Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) | | |
| | | | SUR703.042 | Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors | | |
| | | | SUR703.033 | Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas | | |
| | | | SUR703.030 | Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) | | |
| | | | SUR703.037 | Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML) | | |
| | | | SUR703.038 | Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer | | |
| | | | SUR703.034 | Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia | | |
| | | | SUR703.046 | Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma | | |
| | | | SUR703.050 | Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) | | |
| | | | SUR703.041 | Hematopoietic Cell Transplantation (HCT) or Additional Infusion | | |
| | | | SUR703.036 | | | |
| | | | SUR703.047 | | | |
| | | | SUR703.029 | | | |
| | | | SUR703.032 | | | |
| | | | SUR703.031 | | | |
| | | | SUR703.043 | | | |
| | | | SUR703.045 | | | |
| | | | SUR703.035 | | | |
| | | | SUR703.040 | | | |
| | | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR703.002 | | | |
| | | | SUR703.044 | | | |
| | Harvest Allogeneic Stem Cell | | SUR703.039 | | _ | _ |
| 38206 | | | | Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) | | |
| | | | SUR703.042 | Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors | | |
| | | | SUR703.030 | Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas | | |
| | | | SUR703.033 | Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) | | |
| | | | SUR703.037 | Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML) | | |
| | | | SUR703.038 | Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer | | |
| | | | SUR703.034 | Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia | | |
| | | | SUR703.046 | Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma | | |
| | | | SUR703.050 | Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) | | |
| | | | SUR703.051 | Hematopoietic Cell Transplantation (HCT) or Additional Infusion | | |
| | | | SUR703.041 | | | |
| | | | SUR703.036 | | | |
| | | | SUR703.047 | | | |
| | | | SUR703.029 | | | |
| | | | SUR703.032 | | | |
| | | | SUR703.031 | | | |
| | | | SUR703.043 | | | |
| | | | SUR703.045 | | | |
| | | | SUR703.035 | | | |
| | | | SUR703.040 | | | |
| | | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR703.002 | | | |
| | | | SUR703.044 | | | |
| | Harvest Auto Stem Cells | | SUR703.039 | | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 38207 | | | | Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)<br>Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors<br>Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas<br>Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) | | |
| | | | SUR703.042<br>SUR703.033<br>SUR703.030<br>SUR703.037<br>SUR703.038<br>SUR703.034<br>SUR703.046<br>SUR703.050<br>SUR703.041<br>SUR703.036<br>SUR703.047<br>SUR703.029<br>SUR703.032<br>SUR703.031<br>SUR703.043<br>SUR703.045<br>SUR703.035<br>SUR703.040<br>SUR703.002<br>SUR703.044 | Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML)<br>Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer<br>Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma<br>Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL)<br>Hematopoietic Cell Transplantation (HCT) or Additional Infusion<br>Following Preparative Regimens (General Donor and Recipient Information) | | |
| | Cryopreserve Stem Cells | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR703.039 | Hematopoietic Cell | _ | _ |
| 38208 | | | | Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)<br>Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors<br>Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas<br>Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) | | |
| | | | SUR703.042<br>SUR703.033<br>SUR703.030<br>SUR703.037<br>SUR703.038<br>SUR703.034<br>SUR703.046<br>SUR703.050<br>SUR703.041<br>SUR703.036<br>SUR703.047<br>SUR703.029<br>SUR703.032<br>SUR703.031<br>SUR703.043<br>SUR703.045<br>SUR703.035<br>SUR703.040<br>SUR703.002<br>SUR703.044 | Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML)<br>Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer<br>Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma<br>Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL)<br>Hematopoietic Cell Transplantation (HCT) or Additional Infusion<br>Following Preparative Regimens (General Donor and Recipient Information) | | |
| | Thaw Preserved Stem Cells | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR703.039 | Hematopoietic Cell | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 38209 | | | | Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)<br>Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors<br>Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas<br>Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) | | |
| | | | SUR703.042<br>SUR703.033<br>SUR703.030<br>SUR703.037<br>SUR703.038<br>SUR703.034<br>SUR703.046<br>SUR703.050<br>SUR703.041<br>SUR703.036<br>SUR703.047<br>SUR703.029<br>SUR703.032<br>SUR703.031<br>SUR703.043<br>SUR703.045<br>SUR703.035<br>SUR703.040<br>SUR703.002<br>SUR703.044 | Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML)<br>Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer<br>Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma<br>Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL)<br>Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) | | |
| | Wash Harvest Stem Cells | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR703.039 | Hematopoietic Cell | _ | _ |
| 38210 | | | | Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)<br>Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors<br>Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas<br>Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) | | |
| | | | SUR703.042<br>SUR703.033<br>SUR703.030<br>SUR703.037<br>SUR703.038<br>SUR703.034<br>SUR703.046<br>SUR703.050<br>SUR703.041<br>SUR703.036<br>SUR703.047<br>SUR703.029<br>SUR703.032<br>SUR703.031<br>SUR703.043<br>SUR703.045<br>SUR703.035<br>SUR703.040<br>SUR703.002<br>SUR703.044 | Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML)<br>Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer<br>Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma<br>Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL)<br>Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) | | |
| | T-Cell Depletion Of Harvest | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR703.039 | Hematopoietic Cell | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 38211 | | | | Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)<br>Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors<br>Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas<br>Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) | | |
| | | | SUR703.042<br>SUR703.033<br>SUR703.030<br>SUR703.037<br>SUR703.038<br>SUR703.034<br>SUR703.046<br>SUR703.050<br>SUR703.041<br>SUR703.036<br>SUR703.047<br>SUR703.029<br>SUR703.032<br>SUR703.031<br>SUR703.043<br>SUR703.045<br>SUR703.035<br>SUR703.040<br>SUR703.002<br>SUR703.044 | Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML)<br>Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer<br>Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma<br>Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL)<br>Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) | | |
| | Tumor Cell Deplete Of Harvst | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR703.039 | Hematopoietic Cell | _ | _ |
| 38212 | | | | Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)<br>Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors<br>Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas<br>Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) | | |
| | | | SUR703.042<br>SUR703.033<br>SUR703.030<br>SUR703.037<br>SUR703.038<br>SUR703.034<br>SUR703.046<br>SUR703.050<br>SUR703.041<br>SUR703.036<br>SUR703.047<br>SUR703.029<br>SUR703.032<br>SUR703.031<br>SUR703.043<br>SUR703.045<br>SUR703.035<br>SUR703.040<br>SUR703.002<br>SUR703.044 | Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML)<br>Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer<br>Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma<br>Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL)<br>Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) | | |
| | Rbc Depletion Of Harvest | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR703.039 | Hematopoietic Cell | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 38213 | | | | Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)<br>Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors<br>Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas<br>Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) | | |
| | | | SUR703.042<br>SUR703.033<br>SUR703.030<br>SUR703.037<br>SUR703.038<br>SUR703.034<br>SUR703.046<br>SUR703.050<br>SUR703.041<br>SUR703.036<br>SUR703.047<br>SUR703.029<br>SUR703.032<br>SUR703.031<br>SUR703.043<br>SUR703.045<br>SUR703.035<br>SUR703.040<br>SUR703.002<br>SUR703.044 | Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML)<br>Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer<br>Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma<br>Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL)<br>Hematopoietic Cell Transplantation (HCT) or Additional Infusion<br>Following Preparative Regimens (General Donor and Recipient Information) | | |
| | Platelet Deplete Of Harvest | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR703.039 | Hematopoietic Cell | _ | _ |
| 38214 | | | | Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)<br>Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors<br>Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas<br>Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) | | |
| | | | SUR703.042<br>SUR703.033<br>SUR703.030<br>SUR703.037<br>SUR703.038<br>SUR703.034<br>SUR703.046<br>SUR703.050<br>SUR703.041<br>SUR703.036<br>SUR703.047<br>SUR703.029<br>SUR703.032<br>SUR703.031<br>SUR703.043<br>SUR703.045<br>SUR703.035<br>SUR703.040<br>SUR703.002<br>SUR703.044 | Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML)<br>Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer<br>Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma<br>Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL)<br>Hematopoietic Cell Transplantation (HCT) or Additional Infusion<br>Following Preparative Regimens (General Donor and Recipient Information) | | |
| | Volume Deplete Of Harvest | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR703.039 | Hematopoietic Cell | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 38215 | | | | Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)<br>Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors<br>Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas<br>Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) | | |
| | | | SUR703.042<br>SUR703.033<br>SUR703.030<br>SUR703.037<br>SUR703.038<br>SUR703.034<br>SUR703.046<br>SUR703.050<br>SUR703.041<br>SUR703.036<br>SUR703.047<br>SUR703.029<br>SUR703.032<br>SUR703.031<br>SUR703.043<br>SUR703.045<br>SUR703.035<br>SUR703.040<br>SUR703.002<br>SUR703.044 | Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML)<br>Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer<br>Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma<br>Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL)<br>Hematopoietic Cell Transplantation (HCT) or Additional Infusion<br>Following Preparative Regimens (General Donor and Recipient Information) | | |
| | Harvest Stem Cell Concentrte | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR703.039 | Hematopoietic Cell | _ | _ |
| 38230 | | | | Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)<br>Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors<br>Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas<br>Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) | | |
| | | | SUR703.042<br>SUR703.030<br>SUR703.033<br>SUR703.037<br>SUR703.038<br>SUR703.034<br>SUR703.046<br>SUR703.050<br>SUR703.041<br>SUR703.036<br>SUR703.047<br>SUR703.029<br>SUR703.032<br>SUR703.031<br>SUR703.043<br>SUR703.045<br>SUR703.035<br>SUR703.040<br>SUR703.002<br>SUR703.044 | Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML)<br>Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer<br>Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia<br>Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma<br>Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL)<br>Hematopoietic Cell Transplantation (HCT) or Additional Infusion | | |
| | Bone Marrow Harvest Allogen | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR703.039 | Additional Infusion | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 38232 | | | | Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)<br>Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors<br>Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas<br>Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) | | |
| | | | SUR703.042<br>SUR703.030<br>SUR703.033<br>SUR703.037<br>SUR703.038<br>SUR703.034<br>SUR703.046<br>SUR703.050<br>SUR703.041<br>SUR703.036<br>SUR703.047<br>SUR703.029<br>SUR703.032<br>SUR703.031<br>SUR703.043<br>SUR703.045<br>SUR703.035<br>SUR703.040<br>SUR703.002<br>SUR703.044<br>SUR703.039 | Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML)<br>Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer<br>Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia<br>Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma<br>Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL)<br>Hematopoietic Cell Transplantation (HCT) or Additional Infusion | | |
| | Bone Marrow Harvest Autolog | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | | | | |
| 38240 | | | | Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)<br>Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors<br>Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas<br>Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) | | |
| | | | SUR703.042<br>SUR703.033<br>SUR703.030<br>SUR703.037<br>SUR703.038<br>SUR703.034<br>SUR703.046<br>SUR703.050<br>SUR703.041<br>SUR703.036<br>SUR703.047<br>SUR703.029<br>SUR703.032<br>SUR703.031<br>SUR703.043<br>SUR703.045<br>SUR703.035<br>SUR703.040<br>SUR703.002<br>SUR703.044<br>SUR703.039 | Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML)<br>Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer<br>Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma<br>Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL)<br>Hematopoietic Cell Transplantation (HCT) or Additional Infusion<br>Following Preparative Regimens (General Donor and Recipient Information)<br>Hematopoietic Cell | | |
| | Transplt Allo Hct/Donor | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| 38241 | | | | Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)<br>Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors<br>Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas<br>Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) | | |
| | | | SUR703.042<br>SUR703.030<br>SUR703.033<br>SUR703.037<br>SUR703.038<br>SUR703.034<br>SUR703.046<br>SUR703.050<br>SUR703.041<br>SUR703.036<br>SUR703.047<br>SUR703.029<br>SUR703.032<br>SUR703.031<br>SUR703.043<br>SUR703.045<br>SUR703.035<br>SUR703.040 | Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML)<br>Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer<br>Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia<br>Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma<br>Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) | | |
| | Transplt Autol Hct/Donor | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR703.002<br>SUR703.044<br>SUR703.039 | Hematopoietic Cell Transplantation (HCT) or Additional Infusion | _ | _ |
| 38242 | | | | Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)<br>Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors<br>Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas<br>Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) | | |
| | | | SUR703.042<br>SUR703.033<br>SUR703.030<br>SUR703.037<br>SUR703.038<br>SUR703.034<br>SUR703.046<br>SUR703.050<br>SUR703.041<br>SUR703.036<br>SUR703.047<br>SUR703.029<br>SUR703.032<br>SUR703.031<br>SUR703.043<br>SUR703.045<br>SUR703.035 | Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML)<br>Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer<br>Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma<br>Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL)<br>Hematopoietic Cell Transplantation (HCT) or Additional Infusion | | |
| | Transplt Allo Lymphocytes | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR703.040<br>SUR703.002<br>SUR703.044<br>SUR703.039 | Following Preparative Regimens (General Donor and Recipient Information)<br>Hematopoietic Cell | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 38243 | Transplj Hematopoietic Boost | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR703.042<br>SUR703.033<br>SUR703.030<br>SUR703.037<br>SUR703.038<br>SUR703.034<br>SUR703.046<br>SUR703.050<br>SUR703.041<br>SUR703.036<br>SUR703.047<br>SUR703.029<br>SUR703.032<br>SUR703.031<br>SUR703.043<br>SUR703.045<br>SUR703.035<br>SUR703.040<br>SUR703.002<br>SUR703.044<br>SUR703.039 | Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)<br>Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors<br>Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas<br>Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML)<br>Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML)<br>Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer<br>Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma<br>Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL)<br>Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information)<br>Hematopoietic Cell | _ | _ |
| 38308 | Incision Of Lymph Channels | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.024 | Surgery for Lipedema and Lymphedema | _ | _ |
| 38589 | Laparoscope Proc Lymphatic | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 38999 | Blood/Lymph System Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 39499 | Chest Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 39599 | Diaphragm Surgery Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 40799 | Lip Surgery Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 40899 | Mouth Surgery Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 41019 | Place Needles H&N For Rt | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 41120 | Partial Removal Of Tongue | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR706.009 | Sleep Related Breathing Disorders: Surgical Management | _ | _ |
| 41512 | Tongue Suspension | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR706.009 | Sleep Related Breathing Disorders: Surgical Management | _ | _ |
| 41530 | Tongue Base Vol Reduction | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR706.009<br>SUR701.021 | Radiofrequency Ablation (RFA) of Solid Tumors, Excluding Liver<br>Sleep Related Breathing Disorders: Surgical Management | _ | _ |
| 41599 | Tongue And Mouth Surgery | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 41899 | Dental Surgery Procedure | 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR706.009 | Sleep Related Breathing Disorders: Surgical Management | _ | _ |
| 42145 | Repair Palate Pharynx/Uvula | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR706.009 | Sleep Related Breathing Disorders: Surgical Management | _ | _ |
| 42299 | Palate/Uvula Surgery | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 42699 | Salivary Surgery Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 42999 | Throat Surgery Procedure | 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.019<br>MED201.016 | Botulinum Toxin Device Therapies for Gastroesophageal Reflux Disease (GERD) | _ | _ | |
| 43201 | Esoph Scope W/Submucous Inj | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.019<br>MED201.016 | Botulinum Toxin Device Therapies for Gastroesophageal Reflux Disease (GERD) | _ | _ | |
| 43206 | Esoph Optical Endomicroscopy | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED201.038 | Confocal Laser Endomicroscopy (CLE) | _ | _ | |
| 43210 | Egd Esophagogastrc Fndoplsty | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.016 | Device Therapies for Gastroesophageal Reflux Disease (GERD) | _ | _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.019<br>SUR716.003<br>MED201.016 | Bariatric Surgery<br>Botulinum Toxin Device Therapies for Gastroesophageal Reflux Disease (GERD) | _ | _ | |
| 43252 | Egd Optical Endomicroscopy | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED201.038 | Confocal Laser Endomicroscopy (CLE) | _ | _ | |
| 43253 | Egd Us Transmural Injxn/Mark | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.016 | Device Therapies for Gastroesophageal Reflux Disease (GERD) | _ | _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.016 | Device Therapies for Gastroesophageal Reflux Disease (GERD) | _ | _ | |
| 43284 | Laps Esophgl Sphnctr Agmntj | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR709.036 | Magnetic Esophageal Ring to Treat Gastroesophageal Reflux Disease (GERD) | _ | _ | |
| 43285 | Rmvl Esophgl Sphnctr Dev | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR709.036 | Magnetic Esophageal Ring to Treat Gastroesophageal Reflux Disease (GERD) | _ | _ | |
| 43289 | Laparoscope Proc Esoph | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.016 | Device Therapies for Gastroesophageal Reflux Disease (GERD) | _ | _ | |
| 43305 | Repair Esophagus And Fistula | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR709.032 | Plugs for Fistula Repair | _ | | 6/30/2022 |
| 43312 | Repair Esophagus And Fistula | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR709.032 | Plugs for Fistula Repair | _ | _ | |
| 43499 | Esophagus Surgery Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. May require Prior Authorization based on contract agreement until 03/31/2022. | _ | _ | _ | _ | |
| 43633 | Removal Of Stomach Partial | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.003 | Bariatric Surgery | _ | _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.003 | Bariatric Surgery | _ | _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.003 | Bariatric Surgery | _ | _ | |
| 43647 | Lap Impl Electrode Antrum | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR709.031 | Gastric Electrical Stimulation (GES) | _ | _ | |
| 43648 | Lap Revise/Remv Eltrd Antrum | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR709.031 | Gastric Electrical Stimulation (GES) | _ | _ | |
| 43659 | Laparoscope Proc Stom | 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.003 | Bariatric Surgery | _ | _ | |
| 43771 | Lap Revise Gastr Adj Device | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.003 | Bariatric Surgery | _ | _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.003 | Bariatric Surgery | _ | _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.003 | Bariatric Surgery | _ | _ | |

| | | | | | | |
|---|---|---|---|---|---|---|
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.003 | Bariatric Surgery | _ | _ |
| 43775 | Lap Sleeve Gastrectomy | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.003 | Bariatric Surgery | _ | _ |
| 43842 | V-Band Gastroplasty | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.003 | Bariatric Surgery | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.003 | Bariatric Surgery | _ | _ |
| 43845 | Gastroplasty Duodenal Switch | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.003 | Bariatric Surgery | _ | _ |
| 43846 | Gastric Bypass For Obesity | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.003 | Bariatric Surgery | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.003 | Bariatric Surgery | _ | _ |
| 43848 | Revision Gastroplasty | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.003 | Bariatric Surgery | _ | _ |
| 43860 | Revise Stomach-Bowel Fusion | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 2/15/2022 | _ |
| 43881 | Impl/Redo Electrd Antrum | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR709.031 | Gastric Electrical Stimulation (GES) | _ | _ |
| 43886 | Revise Gastric Port Open | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.003 | Bariatric Surgery | _ | _ |
| 43887 | Remove Gastric Port Open | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.003 | Bariatric Surgery | _ | _ |
| 43888 | Change Gastric Port Open | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.003 | Bariatric Surgery | _ | _ |
| 43999 | Stomach Surgery Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 44238 | Laparoscope Proc Intestine | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 44640 | Repair Bowel-Skin Fistula | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR709.032 | Plugs for Fistula Repair | _ | _ |
| 44705 | Prepare Fecal Microbiota | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR703.049 | Fecal Microbiota Transplantation (FMT) | _ | _ |
| 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 | Bowel Surgery Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 44979 | Laparoscope Proc App | 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 | Rectum Surgery Procedure | 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). | SUR709.032 | Plugs for Fistula Repair | _ | _ |
| 46999 | Anus Surgery Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 47370 | Laparo Ablate Liver Tumor Rf | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR709.029 | Radiofrequency Ablation (RFA) of Primary or Metastatic Liver Tumors | _ | _ |
| 47379 | Laparoscope Procedure 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR709.029 | Radiofrequency Ablation (RFA) of Primary or Metastatic Liver Tumors | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 47381 | Open Ablate Liver Tumor Cryo | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.032 | Cryosurgical Ablation of Primary or Metastatic Liver Tumors | _ | _ |
| 47382 | Percut Ablate Liver Rf | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR709.029<br>SUR701.038 | Microwave Tumor Ablation<br>Radiofrequency Ablation (RFA) of Primary or Metastatic Liver Tumors | _ | _ |
| 47399 | Liver Surgery Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 47579 | Laparoscope Proc Biliary | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 47999 | Bile Tract Surgery Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. May require Prior Authorization based on contract agreement until 03/31/2022. | _ | _ | _ | _ |
| 48999 | Pancreas Surgery Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 49329 | Laparo Proc Abdm/Per/Oment | 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | _ | _ |
| 49412 | Ins Device For Rt Guide Open | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | _ | _ |
| 49659 | Laparo Proc Hernia Repair | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 49999 | Abdomen Surgery Procedure | 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.018 | Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors | _ | _ |
| 50360 | Transplantation Of Kidney | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR703.013<br>SUR703.008<br>SUR703.007 | Kidney Transplant<br>Pancreas and Related Organ Tissue Transplantation<br>Liver Transplant and Combined Liver-Kidney Transplant | _ | _ |
| 50541 | Laparo Ablate Renal Cyst | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.018<br>SUR701.021 | Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors<br>Radiofrequency Ablation (RFA) of Solid Tumors, Excluding Liver | _ | _ |
| 50542 | Laparo Ablate Renal Mass | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.018<br>SUR701.021 | Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors<br>Radiofrequency Ablation (RFA) of Solid Tumors, Excluding Liver | _ | _ |
| 50549 | Laparoscope Proc 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.038<br>SUR701.021 | Microwave Tumor Ablation<br>Radiofrequency Ablation (RFA) of Solid Tumors, Excluding Liver | _ | _ |
| 50593 | Perc Cryo Ablate Renal Tum | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.018 | Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors | _ | _ |
| 50949 | Laparoscope Proc 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR710.008 | Injectable Bulking Agents for the Treatment of Urinary and Fecal Incontinence | _ | _ |
| 51999 | Laparoscope Proc Bla | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 52287 | Cystoscopy Chemodenervation | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.019 | Botulinum Toxin | _ | _ |
| 52327 | Cystoscopy Inject Material | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR710.022 | Periureteral Bulking Agents as a Treatment of Vesicoureteral Reflux (VUR) | _ | _ |
| 52441 | Cystourethro W/Implant | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR710.023 | Prostatic Urethral Lift (PUL) for the Treatment of Benign Prostatic Hyperplasia (BPH) | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 52442 | Cystourethro W/Addl Implant | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR710.023 | Prostatic Urethral Lift (PUL) for the Treatment of Benign Prostatic Hyperplasia (BPH) | _ | _ |
| 53855 | Insert Prost Urethral Stent | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.025 | Temporary Prostatic Stent | _ | _ |
| 53860 | Transurethral Rf Treatment | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR710.021 | Radiofrequency Energy Therapy for Stress Urinary Incontinence (SUI) | _ | _ |
| 53899 | Urology Surgery Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 54110 | Treatment Of Penis Lesion | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.030 | Sexual Dysfunctions, Assessment and Treatment | _ | _ |
| 54111 | Treat Penis Lesion Graft | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.030 | Sexual Dysfunctions, Assessment and Treatment | _ | _ |
| 54112 | Treat Penis Lesion Graft | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.030 | Sexual Dysfunctions, Assessment and Treatment | _ | _ |
| 54125 | Removal Of Penis | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR717.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services | _ | _ |
| 54200 | Treatment Of Penis Lesion | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.073<br>MED201.030 | Clostridial Collagenase for Fibroproliferative Disorders<br>Sexual Dysfunctions, Assessment and Treatment | _ | _ |
| 54205 | Treatment Of Penis Lesion | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.073<br>MED201.030 | Clostridial Collagenase for Fibroproliferative Disorders<br>Sexual Dysfunctions, Assessment and Treatment | _ | _ |
| 54235 | Penile Injection | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.073<br>MED201.030 | Clostridial Collagenase for Fibroproliferative Disorders<br>Sexual Dysfunctions, Assessment and Treatment | _ | _ |
| 54240 | Penis Study | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.030 | Sexual Dysfunctions, Assessment and Treatment | _ | _ |
| 54360 | Penis Plastic Surgery | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.030 | Sexual Dysfunctions, Assessment and Treatment | _ | _ |
| 54400 | Insert Semi-Rigid Prosthesis | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR717.001<br>MED201.030 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Sexual Dysfunctions, Assessment and Treatment | _ | _ |
| 54401 | Insert Self-Contd Prosthesis | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR717.001<br>MED201.030 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Sexual Dysfunctions, Assessment and Treatment | _ | _ |
| 54405 | Insert Multi-Comp Penis Pros | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR717.001<br>MED201.030 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Sexual Dysfunctions, Assessment and Treatment | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR717.001<br>MED201.030 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Sexual Dysfunctions, Assessment and Treatment | _ | _ |
| 54408 | Repair Multi-Comp Penis Pros | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR717.001<br>MED201.030 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Sexual Dysfunctions, Assessment and Treatment | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 54410 | Remove/Replace Penis Prosth | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR717.001<br>MED201.030 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Sexual Dysfunctions, Assessment and Treatment | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR717.001<br>MED201.030 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Sexual Dysfunctions, Assessment and Treatment | _ | _ |
| 54415 | Remove Self-Contd Penis Pros | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR717.001<br>MED201.030 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Sexual Dysfunctions, Assessment and Treatment | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR717.001<br>MED201.030 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Sexual Dysfunctions, Assessment and Treatment | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR717.001<br>MED201.030 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Sexual Dysfunctions, Assessment and Treatment | _ | _ |
| 54440 | Repair Of Penis | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| 54660 | Revision Of Testis | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001<br>SUR717.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Cosmetic and Reconstructive Procedures | _ | _ |
| 54699 | Laparoscope Proc 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 | Laparo Proc Spermatic 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR717.015 | Saturation Biopsy for Diagnosis, Staging and Management of Prostate Cancer, Including Comprehensive 3D Mapping with Biopsy | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR717.004 | Cryosurgical Ablation of the Prostate | _ | _ |
| 55876 | Place Rt Device/Marker Pros | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR717.014 | High-Intensity Focused Ultrasound (HIFU) for Treatment of Cancer | 2/1/2021 | _ |
| 55899 | Genital Surgery Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. May require Prior Authorization based on contract agreement until 03/31/2022. | _ | _ | _ | _ |
| 55920 | Place Needles Pelvic For Rt | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR717.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services | _ | _ |
| 55980 | Sex Transformation F To M | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR717.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services | _ | _ |
| 56805 | Repair Clitoris | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR717.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 56810 | Repair Of Perineum | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR717.001<br>MED201.030 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Sexual Dysfunctions, Assessment and Treatment | _ | _ |
| 57155 | Insert Uteri Tandem/Ovoids | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 57156 | Ins Vag Brachytx Device | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 57291 | Construction Of Vagina | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR717.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services | _ | _ |
| 57292 | Construct Vagina With Graft | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR717.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR717.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services | _ | _ |
| 57296 | Revise Vag Graft Open Abd | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR717.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services | _ | _ |
| 57300 | Repair Rectum-Vagina Fistula | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR709.032 | Plugs for Fistula Repair | _ | 6/30/2022 |
| 57305 | Repair Rectum-Vagina Fistula | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR709.032 | Plugs for Fistula Repair | _ | 6/30/2022 |
| 57307 | Fistula Repair & Colostomy | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR709.032 | Plugs for Fistula Repair | _ | _ |
| 57308 | Fistula Repair Transperine | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR709.032 | Plugs for Fistula Repair | _ | 6/30/2022 |
| 57335 | Repair Vagina | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR717.001<br>MED201.030 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Sexual Dysfunctions, Assessment and Treatment | _ | _ |
| 57426 | Revise Prosth Vag Graft Lap | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR717.001 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services | _ | _ |
| 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. | _ | _ | _ | _ |
| 58346 | Insert Heyman Uteri Capsule | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 58578 | Laparo Proc Uterus | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 58579 | Hysteroscope Procedure | 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.033 | Laparoscopic, Percutaneous and Transcervical Techniques for the Myolysis of Uterine Fibroids | _ | _ |
| 58679 | Laparo Proc Oviduct-Ovary | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 58750 | Repair Oviduct | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| 58752 | Revise Ovarian Tube(S) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| 58970 | Retrieval Of Oocyte | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| 58974 | Transfer Of Embryo | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| 58976 | Transfer Of Embryo | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| 58999 | Genital Surgery Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 59074 | FETAL FLUID DRAINAGE W/US | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.016 | Fetal Surgery for Prenatally Diagnosed Malformations | 12/1/2022 | _ |
| 59076 | Fetal Shunt Placement W/Us | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.016 | Fetal Surgery for Prenatally Diagnosed Malformations | _ | _ |
| 59897 | Fetal Invas Px W/Us | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.016 | Fetal Surgery for Prenatally Diagnosed Malformations | _ | _ |
| 59898 | Laparo Proc Ob Care/Deliver | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 59899 | Maternity Care Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 60659 | Laparo Proc Endocrine | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 60699 | Endocrine Surgery Procedure | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.031 | Magnetic Resonance Image Guided Laser Interstitial Tumor Therapy (LITT) | 10/1/2022 | _ |
| 60699 | Endocrine Surgery Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 61215 | Insert Brain-Fluid Device | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.008 | Implantable Infusion Pump for Pain and Spasticity | _ | _ |
| 61630 | Intracranial Angioplasty | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR701.027<br>MED202.064 | Diagnosis and Treatment of Chronic Cerebrospinal Venous Insufficiency in Multiple Sclerosis<br>Intracranial Stenting or Angioplasty, including Endovascular Procedures | _ | _ |
| 61645 | Perq Art M-Thrombect &/Nfs | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.027 | Intracranial Stenting or Angioplasty, including Endovascular Procedures | _ | _ |
| 61650 | Evasc Prlng Admn Rx Agnt 1St | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.027 | Intracranial Stenting or Angioplasty, including Endovascular Procedures | _ | _ |
| 61651 | Evasc Prlng Admn Rx Agnt Add | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.027 | Intracranial Stenting or Angioplasty, including Endovascular Procedures | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.031 | Magnetic Resonance Image Guided Laser Interstitial Tumor Therapy (LITT) | 5/1/2022 | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.031 | Magnetic Resonance Image Guided Laser Interstitial Tumor Therapy (LITT) | 5/1/2022 | _ |
| 61796 | Srs Cranial Lesion Simple | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 61797 | Srs Cran Les Simple Addl | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 61798 | Srs Cranial Lesion Complex | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 61799 | Srs Cran Les Complex Addl | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 61800 | Apply Srs Headframe Add-On | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 61850 | Implant Neuroelectrodes | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR712.039<br>SUR712.025 | Responsive Neurostimulation (RNS) for the Treatment of Refractory Focal Epilepsy<br>Deep Brain Stimulation (DBS) | _ | 10/1/2022 |
| 61863 | Implant Neuroelectrode | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR714.009<br>SUR712.025<br>SUR712.039 | Auditory Brainstem Implant<br>Deep Brain Stimulation (DBS)<br>Responsive Neurostimulation (RNS) for the Treatment of Refractory Focal Epilepsy | _ | 10/1/2022 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 61864 | Implant Neuroelectrde Addl | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR714.009<br>SUR712.025<br>SUR712.039 | Auditory Brainstem Implant<br>Deep Brain Stimulation (DBS)<br>Responsive Neurostimulation (RNS) for the Treatment of Refractory Focal Epilepsy | _ | | 10/1/2022 |
| 61867 | Implant Neuroelectrode | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR714.009<br>SUR712.025 | Auditory Brainstem Implant<br>Deep Brain Stimulation (DBS) | _ | _ | |
| 61868 | Implant Neuroelectrde Addl | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR714.009<br>SUR712.025 | Auditory Brainstem Implant<br>Deep Brain Stimulation (DBS) | _ | _ | |
| 61885 | Insrt/Redo Neurostim 1 Array | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | _ | _ | _ | | 12/31/2021 |
| 61886 | Implant Neurostim Arrays | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR712.021<br>SUR712.025<br>SUR712.039 | Vagus Nerve Stimulation (VNS)<br>Responsive Neurostimulation (RNS) for the Treatment of Refractory Focal Epilepsy<br>Deep Brain Stimulation (DBS) | _ | | 12/31/2021 |
| 62263 | Epidural Lysis Mult Sessions | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR712.024 | Lysis of Epidural Adhesions | 8/1/2022 | _ | |
| 62263 | Epidural Lysis Mult Sessions | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR712.024 | Lysis of Epidural Adhesions | 5/1/2022 | | 7/31/2022 |
| 62264 | Epidural Lysis On Single Day | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR712.024 | Lysis of Epidural Adhesions | 8/1/2022 | _ | |
| 62264 | Epidural Lysis On Single Day | Medical Policy Criteria: Procedure/service may require prior authorization until 03/31/2022. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR712.024 | Lysis of Epidural Adhesions | 5/1/2022 | | 7/31/2022 |
| 62287 | Percutaneous Diskectomy | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR712.004<br>SUR712.037 | Automated Percutaneous Discectomy and Percutaneous Endoscopic Discectomy<br>Decompression of the Intervertebral Disc Using Laser Energy (Laser Discectomy) or Radiofrequency Coblation (Nucleoplasty) | 1/1/2023 | _ | |
| 62287 | Percutaneous Diskectomy | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR712.037<br>SUR712.004 | Automated Percutaneous Discectomy and Percutaneous Endoscopic Discectomy<br>Decompression of the Intervertebral Disc Using Laser Energy (Laser Discectomy) or Radiofrequency Coblation (Nucleoplasty) | _ | | Moved to PA list |
| 62287 | Percutaneous Diskectomy | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR712.004<br>SUR712.037 | Automated Percutaneous Discectomy and Percutaneous Endoscopic Discectomy<br>Decompression of the Intervertebral Disc Using Laser Energy (Laser Discectomy) or Radiofrequency Coblation (Nucleoplasty) | 10/1/2022 | | 12/31/2022 |
| 62350 | Implant Spinal Canal Cath | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR707.008 | Implantable Infusion Pump for Pain and Spasticity | _ | | Moved to PA list |
| 62351 | Implant Spinal Canal Cath | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR707.008 | Implantable Infusion Pump for Pain and Spasticity | _ | | Moved to PA list |
| 62360 | Insert Spine Infusion Device | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR707.008 | Implantable Infusion Pump for Pain and Spasticity | _ | | Moved to PA list |
| 62361 | Implant Spine Infusion Pump | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR707.008 | Implantable Infusion Pump for Pain and Spasticity | _ | | Moved to PA list |
| 62362 | Implant Spine Infusion Pump | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR707.008 | Implantable Infusion Pump for Pain and Spasticity | _ | | Moved to PA list |
| 62380 | Ndsc Dcmprn 1 Ntrspc Lumbar | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR712.004 | Automated Percutaneous Discectomy and Percutaneous Endoscopic Discectomy | _ | | Moved to PA list |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 63620 | Srs Spinal Lesion | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | | Moved to PA list |
| 63621 | Srs Spinal Lesion Addl | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | | Moved to PA list |
| 63650 | Implant Neuroelectrodes | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR712.009 | Spinal Cord Stimulation (SCS) and Dorsal Root Ganglion (DRG) Stimulation | _ | | Moved to PA list |
| 63655 | Implant Neuroelectrodes | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR712.009 | Spinal Cord Stimulation (SCS) and Dorsal Root Ganglion (DRG) Stimulation | _ | | Moved to PA list |
| 63685 | Insrt/Redo Spine N Generator | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR712.009 | Spinal Cord Stimulation (SCS) and Dorsal Root Ganglion (DRG) Stimulation | _ | | Moved to PA list |
| 64505 | N Block Spenopalatine Gangl | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.039 | Sphenopalatine Ganglion Block for Headaches or Facial Pain | _ | _ | |
| 64553 | Implant Neuroelectrodes | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR712.021<br>SUR705.010 | Vagus Nerve Stimulation (VNS)<br>Temporomandibular Joint (TMJ) Disorders (TMJD) | _ | | 12/31/2021 |
| 64555 | Implant Neuroelectrodes | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR705.010<br>MED205.032 | Temporomandibular Joint (TMJ) Disorders (TMJD)<br>Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS) | _ | _ | |
| 64561 | Implant Neuroelectrodes | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR710.018 | Sacral Nerve Neuromodulation/Stimulation | _ | | 10/1/2022 |
| 64566 | Neuroeltrd Stim Post Tibial | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.035 | Percutaneous Tibial Nerve Stimulation (PTNS) | _ | _ | |
| 64568 | Inc For Vagus N Elect Impl | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR712.033<br>SUR706.009<br>SUR712.021 | Occipital Nerve Stimulation<br>Sleep Related Breathing Disorders: Surgical Management<br>Vagus Nerve Stimulation (VNS) | _ | _ | |
| 64575 | Implant Neuroelectrodes | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.036 | Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS) | _ | | 12/31/2021 |
| 64581 | Implant Neuroelectrodes | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR710.018 | Sacral Nerve Neuromodulation/Stimulation | _ | | 10/1/2022 |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR706.009 | Sleep Related Breathing Disorders: Surgical Management | | 5/1/2022 | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR706.009 | Sleep Related Breathing Disorders: Surgical Management | | 5/1/2022 | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR706.009 | Sleep Related Breathing Disorders: Surgical Management | | 5/1/2022 | |
| 64590 | Insrt/Redo Pn/Gastr Stimul | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR710.018<br>SUR709.031<br>MED205.032 | Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS)<br>Gastric Electrical Stimulation (GES)<br>Sacral Nerve Neuromodulation/Stimulation | _ | _ | |
| 64615 | Chemodenerv Musc Migraine | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.019 | Botulinum Toxin | _ | _ | |
| 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). | SUR702.020 | Intraosseous Radiofrequency Nerve Ablation of the Basivertebral Nerve for the Treatment of Low Back Pain | | 8/1/2022 | _ |
| 64628 | Trml Dstrj Ios Bvn 1St 2 L/S | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR702.020 | Intraosseous Radiofrequency Nerve Ablation of the Basivertebral Nerve for the Treatment of Low Back Pain | | 5/1/2022 | 7/31/2022 |

| | | | | | | |
|---|---|---|---|---|---|---|
| 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). | SUR702.020 | Intraosseous Radiofrequency Nerve Ablation of the Basivertebral Nerve for the Treatment of Low Back Pain | 8/1/2022 | _ |
| 64629 | Trml Dstrj Ios Bvn Ea Addl | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR702.020 | Intraosseous Radiofrequency Nerve Ablation of the Basivertebral Nerve for the Treatment of Low Back Pain | 5/1/2022 | 7/31/2022 |
| 64640 | Injection Treatment Of Nerve | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR705.040 | Ablation of Peripheral Nerves to Treat Pain | 4/15/2021 | _ |
| 64650 | Chemodenerv Eccrine Glands | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.014 | Treatment of Hyperhidrosis | _ | _ |
| 64653 | Chemodenerv Eccrine Glands | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.014 | Treatment of Hyperhidrosis | _ | _ |
| 64716 | Revision Of Cranial Nerve | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR712.031 | Surgical Deactivation of Headache Trigger Sites | _ | _ |
| 64732 | Incision Of Brow Nerve | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR712.031 | Surgical Deactivation of Headache Trigger Sites | _ | _ |
| 64734 | Incision Of Cheek Nerve | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR712.031 | Surgical Deactivation of Headache Trigger Sites | _ | _ |
| 64771 | Sever Cranial Nerve | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR712.031 | Surgical Deactivation of Headache Trigger Sites | _ | _ |
| 64802 | Sympathectomy Cervical | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.014 | Treatment of Hyperhidrosis | _ | _ |
| 64804 | Remove Sympathetic Nerves | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.014 | Treatment of Hyperhidrosis | _ | _ |
| 64809 | Remove Sympathetic Nerves | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.014 | Treatment of Hyperhidrosis | _ | _ |
| 64818 | Remove Sympathetic Nerves | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.014 | Treatment of Hyperhidrosis | _ | _ |
| 64820 | Sympathectomy Digital Artery | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.014 | Treatment of Hyperhidrosis | _ | _ |
| 64823 | Sympathectomy Supfc Palmar | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.014 | Treatment of Hyperhidrosis | _ | _ |
| 64999 | Nervous System Surgery | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. May require Prior Authorization based on contract agreement. | SUR712.033 | Occipital Nerve Stimulation | _ | _ |
| 65710 | Corneal Transplant | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR713.001 | Refractive and Therapeutic Keratoplasty | _ | _ |
| 65730 | Corneal Transplant | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR713.001 | Refractive and Therapeutic Keratoplasty | _ | _ |
| 65750 | Corneal Transplant | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR713.001 | Refractive and Therapeutic Keratoplasty | _ | _ |
| 65755 | Corneal Transplant | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR713.001 | Refractive and Therapeutic Keratoplasty | _ | _ |
| 65756 | Corneal Trnspl Endothelial | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | OTH903.029 | Endothelial Keratoplasty | _ | _ |
| 65757 | Prep Corneal Endo Allograft | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | OTH903.029 | Endothelial Keratoplasty | _ | _ |
| 65760 | Revision Of Cornea | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | 1/1/2021 | _ |
| 65765 | Revision Of Cornea | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 65767 | Corneal Tissue Transplant | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR713.001 | Refractive and Therapeutic Keratoplasty | _ | _ |
| 65770 | Revise Cornea With Implant | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | OTH903.030 | Keratoprosthesis | _ | _ |
| 65771 | Radial Keratotomy | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| 65772 | Correction Of Astigmatism | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR713.001 | Refractive and Therapeutic Keratoplasty | _ | _ |
| 65775 | Correction Of Astigmatism | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR713.001 | Refractive and Therapeutic Keratoplasty | _ | _ |
| 65778 | Cover Eye W/Membrane | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR713.031 | Implantation of Intrastromal Corneal Ring Segments | _ | _ |
| 66174 | Translum Dil Eye Canal | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR713.032 | Viscocanalostomy and Canaloplasty | _ | _ |
| 66175 | Trnslum Dil Eye Canal W/Stnt | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR713.032 | Viscocanalostomy and Canaloplasty | _ | _ |
| 66179 | Aqueous Shunt Eye W/O Graft | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR713.034 | Aqueous Shunts and Stents for Glaucoma | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR713.034 | Aqueous Shunts and Stents for Glaucoma | _ | _ |
| 66183 | Insert Ant Drainage Device | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR713.034 | Aqueous Shunts and Stents for Glaucoma | _ | _ |
| 66184 | Revision Of Aqueous Shunt | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR713.034 | Aqueous Shunts and Stents for Glaucoma | _ | _ |
| 66185 | Revise Aqueous Shunt Eye | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR713.034 | Aqueous Shunts and Stents for Glaucoma | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR713.034 | Aqueous Shunts and Stents for Glaucoma | | 3/15/2022 |
| 66991 | Xcapsl Ctrc Rmvl Insj 1+ | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR713.034 | Aqueous Shunts and Stents for Glaucoma | | 3/15/2022 |
| 66999 | Eye Surgery Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 67027 | Implant Eye Drug System | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | OTH903.024 | Intravitreal, Punctum and Intracameral Implants | _ | _ |
| 67028 | Injection Eye Drug | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | OTH903.044<br>OTH903.020<br>OTH903.027<br>OTH903.024<br>OTH903.026<br>OTH903.041 | Faricimab-svoa<br>Intravitreal Angiogenesis Inhibitors for Choroidal Vascular Conditions<br>Intravitreal Angiogenesis Inhibitors for Retinal Vascular Disorders<br>Intravitreal, Punctum, and Intracameral Implants<br>Ocriplasmin for Symptomatic Vitreomacular Adhesion<br>Ranibizumab Injections, Implants and Biosimilars | _ | _ |
| 67221 | Ocular Photodynamic Ther | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | OTH903.015 | Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV) | _ | _ |
| 67225 | Eye Photodynamic Ther Add-On | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | OTH903.015 | Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV) | _ | _ |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 67299 | Eye Surgery Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ | |
| 67399 | Unlisted Px Extraocular Musc | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ | |
| 67599 | Orbit Surgery Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ | |
| 67900 | Repair Brow Defect | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR712.031<br>SUR716.004 | Surgical Deactivation of Headache Trigger Sites<br>Blepharoplasty, Blepharoptosis and Brow Repair | _ | _ | |
| 67901 | Repair Eyelid Defect | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.004 | Blepharoplasty, Blepharoptosis and Brow Repair | _ | _ | |
| 67902 | Repair Eyelid Defect | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.004 | Blepharoplasty, Blepharoptosis and Brow Repair | _ | _ | |
| 67903 | Repair Eyelid Defect | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.004 | Blepharoplasty, Blepharoptosis and Brow Repair | _ | _ | |
| 67904 | Repair Eyelid Defect | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.004 | Blepharoplasty, Blepharoptosis and Brow Repair | _ | _ | |
| 67906 | Repair Eyelid Defect | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.004 | Blepharoplasty, Blepharoptosis and Brow Repair | _ | _ | |
| 67908 | Repair Eyelid Defect | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.004 | Blepharoplasty, Blepharoptosis and Brow Repair | _ | _ | |
| 67999 | Revision Of Eyelid | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ | |
| 68399 | Eyelid Lining Surgery | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ | |
| 68899 | Tear Duct System Surgery | 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001 | Cosmetic and Reconstructive Procedures | _ | _ | |
| 69300 | Revise External Ear | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001 | Cosmetic and Reconstructive Procedures | _ | _ | |
| 69399 | Outer Ear Surgery Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ | |
| 69676 | Remove Middle Ear Nerve | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.014 | Treatment of Hyperhidrosis | _ | _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR706.018 | Balloon Dilation of the Eustachian Tube | 1/15/2021 | _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR706.018 | Balloon Dilation of the Eustachian Tube | 1/15/2021 | _ | |
| 69714 | Implant Temple Bone W/Stimul | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR714.003 | Implantable Bone-Conduction and Bone-Anchored Hearing Aids | _ | _ | |
| 69715 | Temple Bne Implnt W/Stimulat | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR714.003 | Implantable Bone-Conduction and Bone-Anchored Hearing Aids | _ | | 12/31/2021 |
| 69717 | Temple Bone Implant Revision | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR714.003 | Implantable Bone-Conduction and Bone-Anchored Hearing Aids | _ | _ | |
| 69718 | Revise Temple Bone Implant | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR714.003 | Implantable Bone-Conduction and Bone-Anchored Hearing Aids | _ | | 12/31/2021 |
| 69799 | Middle Ear Surgery Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ | |
| 69930 | Implant Cochlear Device | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR714.004 | Cochlear Implant | _ | _ | |
| 69949 | Inner Ear Surgery Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ | |
| 69979 | Temporal Bone Surgery | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ | |
| 70554 | Fmri Brain By Tech | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | | Moved to PA list |
| 70555 | Fmri Brain By Phys/Psych | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | | Moved to PA list |

| | | | | | | |
|---|---|---|---|---|---|---|
| 74261 | Ct Colonography Dx | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 74262 | Ct Colonography Dx W/Dye | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 74263 | Ct Colonography Screening | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 75571 | Ct Hrt W/O Dye W/Ca Test | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RAD604.009 | Computed Tomography to Detect Coronary Artery Calcification | _ | Moved to PA list |
| 75894 | X-Rays Transcath Therapy | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.027<br>RAD601.047<br>SUR701.015<br>THE801.022 | Intracranial Stenting or Angioplasty, including Endovascular Procedures<br>Radioembolization for Primary and Metastatic Tumors of the Liver<br>Therapeutic Embolization and Vessel Occlusion to Treat Pelvic Conditions<br>Transcatheter Arterial Chemoembolization (TACE) of the Liver | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.057 | Endovascular Stent Grafts for Disorders of the Thoracic Aorta | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.057 | Endovascular Stent Grafts for Disorders of the Thoracic Aorta | _ | _ |
| 75958 | Xray Place Prox Ext Thor Ao | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.057 | Endovascular Stent Grafts for Disorders of the Thoracic Aorta | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.057 | Endovascular Stent Grafts for Disorders of the Thoracic Aorta | _ | _ |
| 76120 | Cine/Video X-Rays | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RAD601.046<br>SUR705.010 | Dynamic Spinal Visualization and Vertebral Motion Analysis<br>Temporomandibular Joint (TMJ) Disorders (TMJD) | _ | _ |
| 76125 | Cine/Video X-Rays Add-On | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RAD601.046<br>SUR705.010 | Dynamic Spinal Visualization and Vertebral Motion Analysis<br>Temporomandibular Joint (TMJ) Disorders (TMJD) | _ | _ |
| 76390 | Mr Spectroscopy | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | PSY301.014 | Autism Spectrum Disorders (ASD) | _ | Moved to PA list |
| 76496 | Fluoroscopic Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 76497 | Ct Procedure | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | N/A | N/A | _ | _ |
| 76498 | Mri Procedure | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | N/A | N/A | _ | _ |
| 76499 | Radiographic Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 76800 | Us Exam Spinal Canal | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | _ | 6/30/2022 |
| 76873 | Echograp Trans R Pros Study | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 76940 | Us Guide Tissue Ablation | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR709.029<br>SUR701.038<br>SUR701.021<br>SUR701.018<br>SUR701.032 | Microwave Tumor Ablation<br>Cryosurgical Ablation of Primary or Metastatic Liver Tumors<br>Radiofrequency Ablation (RFA) of Solid Tumors, Excluding Liver<br>Radiofrequency Ablation (RFA) of Primary or Metastatic Liver Tumors<br>Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors | _ | _ |
| 76948 | Echo Guide Ova Aspiration | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 76965 | Echo Guidance Radiotherapy | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.032<br>SUR701.018<br>SUR701.021 | Cryosurgical Ablation of Primary or Metastatic Liver Tumors<br>Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors<br>Radiofrequency Ablation (RFA) of Solid Tumors, Excluding Liver | _ | _ |
| 77014 | Ct Scan For Therapy Guide | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 77022 | Mri Gdn Parnchyma Tiss Abltj | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.032<br>SUR701.018<br>SUR701.021 | Cryosurgical Ablation of Primary or Metastatic Liver Tumors<br>Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors<br>Radiofrequency Ablation (RFA) of Solid Tumors, Excluding Liver | _ | 12/31/2021 |
| 77049 | Mri Breast C-+ W/Cad Bi | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 77299 | Radiation Therapy Planning | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | N/A | N/A | _ | _ |
| 77316 | Brachytx Isodose Plan Simple | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 77317 | Brachytx Isodose Intermed | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 77318 | Brachytx Isodose Complex | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 77338 | Design Mlc Device For Imrt | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 77371 | Srs Multisource | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 77372 | Srs Linear Based | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 77373 | Sbrt Delivery | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 77385 | Ntsty Modul Rad Tx Dlvr Smpl | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 77386 | Ntsty Modul Rad Tx Dlvr Cplx | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 77387 | Guidance For Radj Tx Dlvr | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 77399 | External Radiation Dosimetry | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RAD601.047 | Radioembolization for Primary and Metastatic Tumors of the Liver | _ | _ |
| 77401 | Radiation Treatment Delivery | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | AIM Guidelines | _ | _ | 12/31/2021 |
| 77402 | Radiation Treatment Delivery | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 77407 | Radiation Treatment Delivery | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 77423 | Neutron Beam Tx Complex | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | AIM Guidelines | _ | _ | 12/31/2021 |
| 77424 | Io Rad Tx Delivery By X-Ray | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 77425 | Io Rad Tx Deliver By Elctrns | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |

| | | | | | | |
|---|---|---|---|---|---|---|
| 77432 | Stereotactic Radiation Trmt | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 77435 | Sbrt Management | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 77469 | Io Radiation Tx Management | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 77499 | Radiation Therapy Management | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | N/A | N/A | _ | _ |
| 77520 | Proton Trmt Simple W/O Comp | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 77522 | Proton Trmt Simple W/Comp | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 77523 | Proton Trmt Intermediate | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 77525 | Proton Treatment Complex | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 77610 | Hyperthermia Treatment | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | AIM Guidelines | _ | _ | 12/31/2021 |
| 77615 | Hyperthermia Treatment | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | AIM Guidelines | _ | _ | 12/31/2021 |
| 77620 | Hyperthermia Treatment | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.029 | Hyperthermic Intraperitoneal Chemotherapy for Select Intra-Abdominal and Pelvic Malignancies | _ | 12/31/2021 |
| 77750 | Infuse Radioactive Materials | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 77761 | Apply Intrcav Radiat Simple | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 77762 | Apply Intrcav Radiat Interm | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 77763 | Apply Intrcav Radiat Compl | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 77767 | Hdr Rdncl Skn Surf Brachytx | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 77768 | Hdr Rdncl Skn Surf Brachytx | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 77770 | Hdr Rdncl Ntrstl/Icav Brchtx | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 77771 | Hdr Rdncl Ntrstl/Icav Brchtx | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 77772 | Hdr Rdncl Ntrstl/Icav Brchtx | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 77778 | Apply Interstit Radiat Compl | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 77790 | Radiation Handling | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 77799 | Radium/Radioisotope Therapy | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | N/A | N/A | _ | _ |
| 78099 | Endocrine Nuclear Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 78199 | Blood/Lymph Nuclear Exam | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 78299 | Gi Nuclear Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 78399 | Musculoskeletal Nuclear Exam | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 78429 | Myocrd Img Pet 1 Std W/Ct | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RAD605.001 | Cardiac Applications of Positron Emission Tomography Scanning | 4/1/2021 | Moved to PA list |
| 78430 | Myocrd Img Pet Rst/Strs W/Ct | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RAD605.001 | Cardiac Applications of Positron Emission Tomography Scanning | _ | Moved to PA list |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 78431 | Myocrd Img Pet Rst&Strs Ct | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RAD605.001 | Cardiac Applications of Positron Emission Tomography Scanning | _ | | Moved to PA list |
| 78432 | Myocrd Img Pet 2Rtracer | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RAD605.001 | Cardiac Applications of Positron Emission Tomography Scanning | | 4/1/2021 | Moved to PA list |
| 78433 | Myocrd Img Pet 2Rtracer Ct | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RAD605.001 | Cardiac Applications of Positron Emission Tomography Scanning | _ | | Moved to PA list |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RAD605.001 | Cardiac Applications of Positron Emission Tomography Scanning | _ | | _ |
| 78459 | Myocrd Img Pet Single Study | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RAD605.001 | Cardiac Applications of Positron Emission Tomography Scanning | _ | | Moved to PA list |
| 78491 | Myocrd Img Pet 1Std Rst/Strs | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RAD605.001 | Cardiac Applications of Positron Emission Tomography Scanning | _ | | Moved to PA list |
| 78492 | Myocrd Img Pet Mlt Rst&Strs | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RAD605.001 | Cardiac Applications of Positron Emission Tomography Scanning | _ | | Moved to PA list |
| 78499 | Cardiovascular Nuclear Exam | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. May require Prior Authorization based on contract agreement until 03/31/2022 | _ | _ | _ | | _ |
| 78599 | Respiratory Nuclear Exam | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | | _ |
| 78608 | Brain Imaging (Pet) | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | PSY301.014 | Autism Spectrum Disorders (ASD) | _ | | Moved to PA list |
| 78609 | Brain Imaging (Pet) | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | PSY301.014 | Autism Spectrum Disorders (ASD) | _ | | Moved to PA list |
| 78699 | Nervous System Nuclear Exam | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | | _ |
| 78799 | Genitourinary Nuclear Exam | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | | _ |
| 78800 | Rp Loclzj Tum 1 Area 1 D Img | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | | Moved to PA list |
| 78801 | Rp Loclzj Tum 2+Area 1+D Img | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | | Moved to PA list |
| 78802 | Rp Loclzj Tum Whbdy 1 D Img | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | | Moved to PA list |
| 78803 | Rp Loclzj Tum Spect 1 Area | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | | Moved to PA list |
| 78804 | Rp Loclzj Tum Whbdy 2+D Img | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | | Moved to PA list |
| 78811 | Pet Image Ltd Area | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | | Moved to PA list |
| 78812 | Pet Image Skull-Thigh | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | | Moved to PA list |
| 78813 | Pet Image Full Body | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | | Moved to PA list |
| 78814 | Pet Image W/Ct Lmtd | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | | Moved to PA list |
| 78815 | Pet Image W/Ct Skull-Thigh | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | | Moved to PA list |
| 78816 | Pet Image W/Ct Full Body | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | | Moved to PA list |
| 78999 | Nuclear Diagnostic Exam | 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RAD601.047 | Radioembolization for Primary and Metastatic Tumors of the Liver | _ | | _ |
| 79999 | Nuclear Medicine Therapy | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | | _ |
| 80299 | Quantitative Assay Drug | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | | _ |
| 81099 | Urinalysis Test Procedure | 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | _ | | _ |
| 81162 | Brca1&2 Gen Full Seq Dup/Del | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | MED208.092 | Genetic Testing for BRCA1 or BRCA2 for Hereditary Breast and Ovarian Cancer Syndrome and Other High-Risk Cancers | _ | | Moved to PA list |

| | | | | | | |
|---|---|---|---|---|---|---|
| 81170 | Abl1 Gene | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81200 | Aspa Gene | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81201 | Apc Gene Full Sequence | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81202 | Apc Gene Known Fam Variants | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81203 | Apc Gene Dup/Delet Variants | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81205 | Bckdhb Gene | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81206 | Bcr/Abl1 Gene Major Bp | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | _ | _ |
| 81208 | Bcr/Abl1 Gene Other Bp | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81209 | Blm Gene | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81210 | Braf Gene | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81212 | Brca1&2 185&5385&6174 Vrnt | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | MED208.092 | Genetic Testing for BRCA1 or BRCA2 for Hereditary Breast and Ovarian Cancer Syndrome and Other High-Risk Cancers | _ | Moved to PA list |
| 81215 | Brca1 Gene Known Famil Vrnt | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | MED208.092 | Genetic Testing for BRCA1 or BRCA2 for Hereditary Breast and Ovarian Cancer Syndrome and Other High-Risk Cancers | _ | Moved to PA list |
| 81216 | Brca2 Gene Full Seq Alys | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | MED208.092 | Genetic Testing for BRCA1 or BRCA2 for Hereditary Breast and Ovarian Cancer Syndrome and Other High-Risk Cancers | _ | Moved to PA list |
| 81217 | Brca2 Gene Known Famil Vrnt | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | MED208.092 | Genetic Testing for BRCA1 or BRCA2 for Hereditary Breast and Ovarian Cancer Syndrome and Other High-Risk Cancers | _ | Moved to PA list |
| 81218 | Cebpa Gene Full Sequence | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | MED208.094 | Genetic Testing for FLT3, NPM1, and CEBPA Variants in Cytogenetically Normal Acute Myeloid Leukemia | _ | Moved to PA list |
| 81219 | Calr Gene Com Variants | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81221 | Cftr Gene Known Fam Variants | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81222 | Cftr Gene Dup/Delet Variants | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81223 | Cftr Gene Full Sequence | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81224 | Cftr Gene Intron Poly T | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81225 | Cyp2C19 Gene Com Variants | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81226 | Cyp2D6 Gene Com Variants | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81227 | Cyp2C9 Gene Com Variants | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81228 | Cytogen Micrarray Copy Nmbr | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81229 | Cytogen M Array Copy No&Snp | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |

| | | | | | | |
|---|---|---|---|---|---|---|
| 81230 | Cyp3A4 Gene Common Variants | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81231 | Cyp3A5 Gene Common Variants | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81232 | Dpyd Gene Common Variants | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81235 | Egfr Gene Com Variants | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81238 | F9 Full Gene Sequence | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81240 | F2 Gene | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81241 | F5 Gene | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | _ | _ |
| 81242 | Fancc Gene | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81243 | Fmr1 Gene Detection | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | _ | _ |
| 81244 | Fmr1 Gene Charac Alleles | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81245 | Flt3 Gene | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | MED208.094 | Genetic Testing for FLT3, NPM1, and CEBPA Variants in Cytogenetically Normal Acute Myeloid Leukemia | _ | Moved to PA list |
| 81246 | Flt3 Gene Analysis | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | MED208.094 | Genetic Testing for FLT3, NPM1, and CEBPA Variants in Cytogenetically Normal Acute Myeloid Leukemia | _ | Moved to PA list |
| 81249 | G6Pd Full Gene Sequence | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81250 | G6Pc Gene | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81251 | Gba Gene | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81252 | Gjb2 Gene Full Sequence | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81253 | Gjb2 Gene Known Fam Variants | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81254 | Gjb6 Gene Com Variants | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81255 | Hexa Gene | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81256 | Hfe Gene | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81257 | Hba1/Hba2 Gene | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81259 | Hba1/Hba2 Full Gene Sequence | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81260 | Ikbkap Gene | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81261 | Igh Gene Rearrange Amp Meth | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81262 | Igh Gene Rearrang Dir Probe | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81263 | Igh Vari Regional Mutation | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81264 | Igk Rearrangeabn Clonal Pop | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |

| | | | | | | |
|---|---|---|---|---|---|---|
| 81265 | | | | Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)<br>Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors<br>Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas<br>Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) | | |
| | | | SUR703.042<br>SUR703.033<br>SUR703.030<br>SUR703.037<br>SUR703.038<br>SUR703.034<br>SUR703.046<br>SUR703.050<br>SUR703.041<br>SUR703.036<br>SUR703.047<br>SUR703.029<br>SUR703.032<br>SUR703.031<br>SUR703.043<br>SUR703.045<br>SUR703.035<br>SUR703.040 | Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML)<br>Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer<br>Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma<br>Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL)<br>Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) | | |
| | Str Markers Specimen Anal | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR703.002<br>SUR703.044<br>SUR703.039 | Hematopoietic Cell | _ | Moved to PA list |
| 81266 | | | | Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)<br>Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors<br>Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas<br>Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) | | |
| | | | SUR703.042<br>SUR703.033<br>SUR703.030<br>SUR703.037<br>SUR703.038<br>SUR703.034<br>SUR703.046<br>SUR703.050<br>SUR703.041<br>SUR703.036<br>SUR703.047<br>SUR703.029<br>SUR703.032<br>SUR703.031<br>SUR703.043<br>SUR703.045<br>SUR703.035<br>SUR703.040 | Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML)<br>Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer<br>Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma<br>Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL)<br>Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) | | |
| | Str Markers Spec Anal Addl | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR703.002<br>SUR703.044<br>SUR703.039 | Hematopoietic Cell | _ | Moved to PA list |
| 81269 | Hba1/Hba2 Gene Dup/Del Vrnts | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81270 | Jak2 Gene | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81271 | Htt Gene Detc Abnor Alleles | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81272 | Kit Gene Targeted Seq Analys | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |

| | | | | | | |
|---|---|---|---|---|---|---|
| 81273 | Kit Gene Analys D816 Variant | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81275 | Kras Gene Variants Exon 2 | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81276 | Kras Gene Addl Variants | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81283 | Ifnl3 Gene | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81284 | Fxn Gene Detc Abnor Alleles | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81287 | Mgmt Gene Prmtr Mthyltn Alys | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81288 | Mlh1 Gene | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81290 | Mcoln1 Gene | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81291 | Mthfr Gene | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81292 | Mlh1 Gene Full Seq | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81293 | Mlh1 Gene Known Variants | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81294 | Mlh1 Gene Dup/Delete Variant | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81295 | Msh2 Gene Full Seq | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81296 | Msh2 Gene Known Variants | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81297 | Msh2 Gene Dup/Delete Variant | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81298 | Msh6 Gene Full Seq | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81299 | Msh6 Gene Known Variants | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81300 | Msh6 Gene Dup/Delete Variant | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81302 | Mecp2 Gene Full Seq | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81303 | Mecp2 Gene Known Variant | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81304 | Mecp2 Gene Dup/Delet Variant | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81310 | Npm1 Gene | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | MED208.094 | Genetic Testing for FLT3, NPM1, and CEBPA Variants in Cytogenetically Normal Acute Myeloid Leukemia | _ | Moved to PA list |
| 81311 | Nras Gene Variants Exon 2&3 | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81313 | Pca3/Klk3 Antigen | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81314 | Pdgfra Gene | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81315 | Pml/Raralpha Com Breakpoints | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81316 | Pml/Raralpha 1 Breakpoint | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81317 | Pms2 Gene Full Seq Analysis | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81318 | Pms2 Known Familial Variants | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |

| | | | | | | |
|---|---|---|---|---|---|---|
| 81319 | Pms2 Gene Dup/Delet Variants | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81321 | Pten Gene Full Sequence | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81322 | Pten Gene Known Fam Variant | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81323 | Pten Gene Dup/Delet Variant | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81324 | Pmp22 Gene Dup/Delet | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81325 | Pmp22 Gene Full Sequence | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81326 | Pmp22 Gene Known Fam Variant | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81328 | Slco1B1 Gene Com Variants | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81330 | Smpd1 Gene Common Variants | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81331 | Snrpn/Ube3A Gene | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81332 | Serpina1 Gene | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81335 | Tpmt Gene Com Variants | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81340 | Trb@ Gene Rearrange Amplify | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81341 | Trb@ Gene Rearrange Dirprobe | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81342 | Trg Gene Rearrangement Anal | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81346 | Tyms Gene Com Variants | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81350 | Ugt1A1 Gene Common Variants | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81355 | Vkorc1 Gene | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81361 | Hbb Gene Com Variants | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81363 | Hbb Gene Dup/Del Variants | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81364 | Hbb Full Gene Sequence | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81400 | Mopath Procedure Level 1 | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81401 | Mopath Procedure Level 2 | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | MED208.089<br>MED207.008 | Novel Biomarkers in Risk Assessment and Management of Cardiovascular Disease<br>Genetic Testing for Mitochondrial Disorders | _ | Moved to PA list |
| 81402 | Mopath Procedure Level 3 | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81403 | Mopath Procedure Level 4 | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | MED208.089 | Genetic Testing for Mitochondrial Disorders | _ | Moved to PA list |
| 81404 | Mopath Procedure Level 5 | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | MED208.089 | Genetic Testing for Mitochondrial Disorders | _ | Moved to PA list |
| 81405 | Mopath Procedure Level 6 | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | MED208.089 | Genetic Testing for Mitochondrial Disorders | _ | Moved to PA list |
| 81406 | Mopath Procedure Level 7 | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | MED208.089 | Genetic Testing for Mitochondrial Disorders | _ | Moved to PA list |
| 81407 | Mopath Procedure Level 8 | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |

| | | | | | | |
|---|---|---|---|---|---|---|
| 81408 | Mopath Procedure Level 9 | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81410 | Aortic Dysfunction/Dilation | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81411 | Aortic Dysfunction/Dilation | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81412 | Ashkenazi Jewish Assoc Dis | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81413 | Car Ion Chnnlpath Inc 10 Gns | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81414 | Car Ion Chnnlpath Inc 2 Gns | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81415 | Exome Sequence Analysis | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81416 | Exome Sequence Analysis | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81417 | Exome Re-Evaluation | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81420 | Fetal Chrmoml Aneuploidy | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | _ | _ |
| 81422 | Fetal Chrmoml Microdeltj | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81425 | Genome Sequence Analysis | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81426 | Genome Sequence Analysis | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81427 | Genome Re-Evaluation | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81430 | Hearing Loss Sequence Analys | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81431 | Hearing Loss Dup/Del Analys | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81432 | Hrdtry Brst Ca-Rlatd Dsordrs | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | MED208.092 | Genetic Testing for BRCA1 or BRCA2 for Hereditary Breast and Ovarian Cancer Syndrome and Other High-Risk Cancers | _ | Moved to PA list |
| 81433 | Hrdtry Brst Ca-Rlatd Dsordrs | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | MED208.092 | Genetic Testing for BRCA1 or BRCA2 for Hereditary Breast and Ovarian Cancer Syndrome and Other High-Risk Cancers | _ | Moved to PA list |
| 81434 | Hereditary Retinal Disorders | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81435 | Hereditary Colon Ca Dsordrs | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81436 | Hereditary Colon Ca Dsordrs | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81437 | Heredtry Nurondcrn Tum Dsrdr | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81438 | Heredtry Nurondcrn Tum Dsrdr | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81439 | Hrdtry Cardmypy Gene Panel | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81440 | Mitochondrial Gene | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | MED208.089 | Genetic Testing for Mitochondrial Disorders | _ | Moved to PA list |
| 81442 | Noonan Spectrum Disorders | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81445 | Targeted Genomic Seq Analys | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81448 | Hrdtry Perph Neurphy Panel | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |

| | | | | | | |
|---|---|---|---|---|---|---|
| 81450 | Targeted Genomic Seq Analys | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81455 | Targeted Genomic Seq Analys | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81460 | Whole Mitochondrial Genome | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | MED208.089 | Genetic Testing for Mitochondrial Disorders | _ | Moved to PA list |
| 81465 | Whole Mitochondrial Genome | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | MED208.089 | Genetic Testing for Mitochondrial Disorders | _ | Moved to PA list |
| 81470 | X-Linked Intellectual Dblt | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81471 | X-Linked Intellectual Dblt | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81479 | Unlisted Molecular Pathology | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. May require Prior Authorization based on contract agreement. | MED208.089 | Genetic Testing for Mitochondrial Disorders | _ | _ |
| 81490 | Autoimmune Rheumatoid Arthr | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED208.091 | Multibiomarker Disease Activity Blood Test for Rheumatoid Arthritis | _ | _ |
| 81493 | Cor Artery Disease Mrna | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81503 | Onco (Ovar) Five Proteins | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | N/A | N/A | _ | _ |
| 81504 | Oncology Tissue Of Origin | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81507 | Fetal Aneuploidy Trisom Risk | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | _ | _ |
| 81519 | Oncology Breast Mrna | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81520 | Onc Breast Mrna 58 Genes | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81521 | Onc Breast Mrna 70 Genes | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81525 | Oncology Colon Mrna | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81535 | Oncology Gynecologic | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | N/A | N/A | _ | _ |
| 81536 | Oncology Gynecologic | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | N/A | N/A | _ | _ |
| 81538 | Oncology Lung | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | N/A | N/A | _ | _ |
| 81539 | Oncology Prostate Prob Score | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED208.093 | 4Kscore for Prostate Cancer Risk Assessment | _ | _ |
| 81540 | Oncology Tum Unknown Origin | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81541 | Onc Prostate Mrna 46 Genes | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81551 | Onc Prostate 3 Genes | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81595 | Cardiology Hrt Trnspl Mrna | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 81599 | Unlisted Maaa | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED207.159 | Serum Biomarker Panel Testing for Systemic Lupus Erythematosus and Other Connective Tissue Diseases | _ | _ |
| 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). | MED207.116 | Bone Turnover Markers for Diagnosis and Management of Osteoporosis and Diseases Associated with High Bone Turnover | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 82777 | Galectin-3 | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED207.158 | Molecular Testing For Chronic Heart Failure and Heart Transplant | _ | _ |
| 83006 | Growth Stimulation Gene 2 | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED207.158 | Molecular Testing For Chronic Heart Failure and Heart Transplant | _ | _ |
| 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). | MED207.008 | Novel Biomarkers in Risk Assessment and Management of Cardiovascular Disease | _ | _ |
| 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). | MED207.134 | Measurement of Phospholipase A2 in the Assessment of Cardiovascular Risk | _ | _ |
| 83701 | Lipoprotein Bld Hr Fraction | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED207.008 | Novel Biomarkers in Risk Assessment and Management of Cardiovascular Disease | _ | _ |
| 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). | MED207.008 | Novel Biomarkers in Risk Assessment and Management of Cardiovascular Disease | _ | _ |
| 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). | MED207.008 | Novel Biomarkers in Risk Assessment and Management of Cardiovascular Disease | _ | _ |
| 83937 | Assay Of Osteocalcin | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED207.116 | Bone Turnover Markers for Diagnosis and Management of Osteoporosis and Diseases Associated with High Bone Turnover | _ | _ |
| 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). | MED201.024 | Measurement of Exhaled Breath Condensate in the Diagnosis and Management of Respiratory Disorders | _ | _ |
| 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). | OB401.018 | Tests for Amniotic Protein to Detect Rupture of Membranes (ROM) in Pregnancy | _ | _ |
| 84431 | Thromboxane Urine | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED207.148 | Measurement of Thromboxane Metabolites in Urine | _ | _ |
| 84999 | Clinical Chemistry Test | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED207.154<br>MED207.088<br>MED207.136<br>MED207.153<br>MED207.128<br>MED207.159<br>OB401.018 | Drug Testing in Pain Management and Substance Use Disorder Monitoring<br>Intracellular Micronutrient Analysis<br>Measurement of Long Chain Omega-3 Fatty Acids in Red Blood Cell Membranes as a Cardiac Risk Factor<br>Measurement of Serum Antibodies to Selected Biologic Agents<br>Salivary Hormone Testing<br>Serum Biomarker Panel Testing for Systemic Lupus Erythematosus and Other Connective Tissue Diseases<br>Tests for Amniotic Protein to Detect Rupture of Membranes (ROM) in Pregnancy | _ | _ |
| 85999 | Hematology Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 86001 | Allergen Specific Igg | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED206.001 | Allergy Management | _ | _ |
| 86343 | Leukocyte Histamine Release | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED206.001 | Allergy Management | _ | _ |
| 86352 | Cell Function Assay W/Stim | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED207.147 | Immune Cellular Function Assay to Monitor and Predict Immune Function | _ | _ |
| 86353 | Lymphocyte Transformation | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED207.088 | Intracellular Micronutrient Analysis | _ | _ |
| 86486 | Skin Test Nos Antigen | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 86849 | Immunology Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 86910 | Blood Typing Paternity Test | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| 86950 | Leukacyte Transfusion | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR703.042<br>SUR703.033<br>SUR703.030<br>SUR703.037<br>SUR703.038<br>SUR703.034<br>SUR703.046<br>SUR703.050<br>SUR703.041<br>SUR703.036<br>SUR703.047<br>SUR703.029<br>SUR703.032<br>SUR703.031<br>SUR703.043<br>SUR703.045<br>SUR703.035<br>SUR703.040<br>SUR703.002<br>SUR703.044<br>SUR703.039 | Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)<br>Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors<br>Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas<br>Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML)<br>Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML)<br>Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer<br>Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma<br>Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL)<br>Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information)<br>Hematopoietic Cell | _ | _ |
| 86999 | Transfusion Procedure | 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED207.155 | Gastrointestinal Panels | _ | _ |
| 87506 | Iadna-Dna/Rna Probe Tq 6-11 | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED207.155 | Gastrointestinal Panels | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED207.155 | Gastrointestinal Panels | _ | _ |
| 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 | Microbiology Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 88099 | Necropsy (Autopsy) Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 88199 | Cytopathology Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 88299 | 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). | MED201.038 | Confocal Laser Endomicroscopy (CLE) | _ | _ |
| 88399 | Surgical Pathology Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 88749 | 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 | Pathology Lab Procedure | 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | OB402.023 | Services for Infertility and Recurrent Fetal Loss | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | OB402.023 | Services for Infertility and Recurrent Fetal Loss | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 89253 | Embryo Hatching | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | OB402.023 | Services for Infertility and Recurrent Fetal Loss | _ | _ |
| 89254 | Oocyte Identification | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| 89255 | Prepare Embryo For Transfer | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| 89257 | Sperm Identification | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| 89258 | Cryopreservation Embryo(S) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| 89259 | Cryopreservation Sperm | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| 89260 | Sperm Isolation Simple | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| 89261 | Sperm Isolation Complex | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| 89264 | Identify Sperm Tissue | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| 89268 | Insemination Of Oocytes | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| 89272 | Extended Culture Of Oocytes | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| 89280 | Assist Oocyte Fertilization | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| 89281 | Assist Oocyte Fertilization | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| 89290 | Biopsy Oocyte Polar Body | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | _ | _ |
| 89291 | Biopsy Oocyte Polar Body | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | _ | _ |
| 89325 | Sperm Antibody Test | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| 89329 | Sperm Evaluation Test | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| 89330 | Evaluation Cervical Mucus | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| 89331 | Retrograde Ejaculation Anal | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| 89335 | Cryopreserve Testicular Tiss | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| 89337 | Cryopreservation Oocyte(S) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| 89342 | Storage/Year Embryo(S) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| 89343 | Storage/Year Sperm/Semen | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| 89344 | Storage/Year Reprod Tissue | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| 89346 | Storage/Year Oocyte(S) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| 89352 | Thawing Cryopresrved Embryo | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| 89353 | Thawing Cryopresrved Sperm | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| 89354 | Thaw Cryoprsvrd Reprod Tiss | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| 89356 | Thawing Cryopresrved Oocyte | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| 89398 | Unlisted Reprod Med Lab Proc | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 90283 | Human Ig Iv | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | PSY301.014<br>RX504.003 | Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) Autism Spectrum Disorders (ASD) | _ | 11/30/2022 |
| 90284 | Human Ig Sc | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX504.003 | Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) | _ | 11/30/2022 |
| 90378 | Rsv Mab Im 50Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX504.009 | Respiratory Syncytial Virus (RSV) Immunoprophylaxis | _ | _ |
| 90399 | 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. | _ | _ | 7/1/2022 | _ |
| 90626 | Tic-Brn Enceph Vac 0.25Ml Im | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | 7/1/2021 | _ |
| 90627 | Tic-Brn Enceph Vac 0.5Ml Im | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | 7/1/2021 | _ |
| 90664 | Laiv Vacc Pandemic Intranasl | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | _ | _ |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | _ | _ | |
| 90671 | Pcv15 Vaccine Im | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | | 7/1/2021 | 7/15/2022 |
| 90749 | 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. | _ | _ | | 1/1/2022 | _ |
| 90867 | Tcranial Magn Stim Tx Plan | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | PSY301.015 | Repetitive Transcranial Magnetic Stimulation (rTMS) | _ | _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | PSY301.015 | Repetitive Transcranial Magnetic Stimulation (rTMS) | _ | _ | |
| 90869 | Tcran Magn Stim Redetemine | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | PSY301.015 | Repetitive Transcranial Magnetic Stimulation (rTMS) | _ | _ | |
| 90870 | Electroconvulsive Therapy | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | PSY301.013 | Electroconvulsive Therapy | _ | _ | |
| 90875 | Psychophysiological Therapy | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | PSY301.018<br>PSY301.017<br>PSY301.019<br>PSY301.016<br>PSY301.007<br>PSY301.011<br>MED205.022 | Biofeedback as a Treatment of Chronic Pain<br>Biofeedback as a Treatment of Fecal Incontinence or Constipation<br>Biofeedback as a Treatment of Headache<br>Biofeedback as a Treatment of Urinary Incontinence<br>Biofeedback for Miscellaneous Indications<br>Neurofeedback<br>Treatment of Tinnitus | _ | _ | |
| 90876 | Psychophysiological Therapy | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | PSY301.018<br>PSY301.017<br>PSY301.019<br>PSY301.016<br>PSY301.007<br>PSY301.011<br>MED205.022 | Biofeedback as a Treatment of Chronic Pain<br>Biofeedback as a Treatment of Fecal Incontinence or Constipation<br>Biofeedback as a Treatment of Headache<br>Biofeedback as a Treatment of Urinary Incontinence<br>Biofeedback for Miscellaneous Indications<br>Neurofeedback<br>Treatment of Tinnitus | _ | _ | |
| 90880 | Hypnotherapy | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.001 | Hypnosis | _ | _ | |
| 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 | Psychiatric Service/Therapy | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ | |
| 90901 | Biofeedback Train Any Meth | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | PSY301.018<br>PSY301.017<br>PSY301.019<br>PSY301.016<br>PSY301.007<br>PSY301.011<br>MED205.022 | Biofeedback as a Treatment of Chronic Pain<br>Biofeedback as a Treatment of Fecal Incontinence or Constipation<br>Biofeedback as a Treatment of Headache<br>Biofeedback as a Treatment of Urinary Incontinence<br>Biofeedback for Miscellaneous Indications<br>Neurofeedback<br>Treatment of Tinnitus | _ | _ | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | PSY301.017<br>PSY301.016 | Biofeedback as a Treatment of Fecal Incontinence or Constipation<br>Biofeedback as a Treatment of Urinary Incontinence | | 4/1/2021 | |
| 90913 | Bfb Training Ea Addl 15 Min | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | PSY301.017<br>PSY301.016 | Biofeedback as a Treatment of Fecal Incontinence or Constipation<br>Biofeedback as a Treatment of Urinary Incontinence | | 4/1/2021 | |
| 90999 | 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.005 | Esophageal pH Monitoring | _ | _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.005 | Esophageal pH Monitoring | _ | _ | |
| 91037 | Esoph Imped Function Test | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.005 | Esophageal pH Monitoring | _ | _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.005 | Esophageal pH Monitoring | _ | _ | |
| 91065 | Breath Hydrogen/Methane Test | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED207.161 | Hydrogen or Methane Breath Testing | _ | _ | |
| 91110 | Gi Tract Capsule Endoscopy | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RAD601.042 | Wireless Capsule Endoscopy (WCE) To Diagnose Disorders of The Small Bowel, Esophagus, And Colon | _ | _ | |
| 91111 | Esophageal Capsule Endoscopy | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | RAD601.042 | Wireless Capsule Endoscopy (WCE) To Diagnose Disorders of The Small Bowel, Esophagus, And Colon | _ | _ | |
| 91112 | Gi Wireless Capsule Measure | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED201.017 | Gastrointestinal (GI) Motility Measurement | _ | _ | |
| 91113 | GI TRC IMG INTRAL COLON I&R | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | RAD601.042 | Wireless Capsule Endoscopy to Diagnose Disorders of The Small Bowel, Esophagus, and Colon | | 1/1/2023 | |
| 91113 | GI TRC IMG INTRAL COLON I&R | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RAD601.042 | Wireless Capsule Endoscopy to Diagnose Disorders of The Small Bowel, Esophagus, and Colon | | 11/1/2022 | 12/31/2022 |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.017 | Gastrointestinal (GI) Motility Measurement | _ | _ | |
| 91132 | Electrogastrography | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED201.017 | Gastrointestinal (GI) Motility Measurement | _ | _ | |
| 91133 | Electrogastrography W/Test | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED201.017 | Gastrointestinal (GI) Motility Measurement | _ | _ | |
| 91299 | Gastroenterology Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ | |
| 92065 | Orthoptic/Pleoptic Training | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | OTH903.012 | Orthoptics (Vergence/Accommodative Therapy), Visual Exercises or Training | _ | _ | |
| 92132 | Cmptr Ophth Dx Img Ant Segmt | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | OTH903.021 | Optical Coherence Tomography of the Anterior Eye Segment | _ | _ | |
| 92145 | Corneal Hysteresis Deter | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | OTH903.031 | Corneal Hysteresis | _ | _ | |
| 92273 | Full Field Erg W/I&R | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | OTH903.036 | Electroretinography (ERG), Multi-focal Electroretinography (mfERG) And Pattern Electroretinography (PERG) | _ | _ | |

| | | | | | | |
|---|---|---|---|---|---|---|
| 92274 | Multifocal Erg W/I&R | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | OTH903.036 | Electroretinography (ERG), Multi-focal Electroretinography (mfERG) And Pattern Electroretinography (PERG) | _ | _ |
| 92499 | Eye Service Or Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 92512 | Nasal Function Studies | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED204.004 | Rhinomanometry, Acoustic Rhinometry, Optical Rhinometry and Acoustic Pharyngometry | _ | _ |
| 92517 | Vemp Test I&R Cervical | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED201.047 | Vestibular Function Testing | 5/15/2021 | _ |
| 92518 | Vemp Test I&R Ocular | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED201.047 | Vestibular Function Testing | 5/15/2021 | _ |
| 92519 | Vemp Tst I&R Cervical&Ocular | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED201.047 | Vestibular Function Testing | 5/15/2021 | _ |
| 92520 | Laryngeal Function Studies | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED204.004 | Rhinomanometry, Acoustic Rhinometry, Optical Rhinometry and Acoustic Pharyngometry | _ | _ |
| 92548 | Cdp-Sot 6 Cond W/I&R | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED205.026 | Dynamic Posturography | _ | _ |
| 92549 | Cdp-Sot 6 Cond W/I&R Mct&Adt | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED205.026 | Dynamic Posturography | _ | _ |
| 92601 | Cochlear Implt F/Up Exam <7 | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR714.004 | Cochlear Implant | _ | _ |
| 92602 | Reprogram Cochlear Implt <7 | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR714.004 | Cochlear Implant | _ | _ |
| 92603 | Cochlear Implt F/Up Exam 7/> | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR714.004 | Cochlear Implant | _ | _ |
| 92609 | Use Of Speech Device Service | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.009 | Speech Generating Devices (SGD) | _ | 8/31/2022 |
| 92633 | Aud Rehab Postling Hear Loss | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR714.004 | Cochlear Implant | _ | _ |
| 92640 | Aud Brainstem Implt Programg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR714.009 | Auditory Brainstem Implant | _ | _ |
| 92700 | Ent Procedure/Service | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 92971 | Cardioassist External | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.050 | Enhanced External Counterpulsation (EECP) | _ | _ |
| 92974 | Cath Place Cardio Brachytx | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | _ | _ |
| 92978 | Endoluminl Ivus Oct C 1St | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.065 | Optical Coherence Tomography for Imaging of Coronary Arteries | _ | _ |
| 92979 | Endoluminl Ivus Oct C Ea | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.065 | Optical Coherence Tomography for Imaging of Coronary Arteries | _ | _ |
| 93025 | Microvolt T-Wave Assess | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.006 | Risk Stratification Tests for Determining Arrhythmias (Signal-Averaged Electrocardiography [SAECG] and Microvolt T-Wave Alternans [MTWA]) | _ | _ |
| 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). | MED202.070 | Non-Invasive Measurement of Central Blood Pressure (cBP) | _ | _ |
| 93228 | Remote 30 Day Ecg Rev/Report | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.003 | Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems) | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.003 | Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems) | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.003 | Implantable Cardioverter Defibrillators | _ | _ |
| 93261 | Interrogate Subq Defib | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.003 | Implantable Cardioverter Defibrillators | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.058 | Cardiac Hemodynamic Monitoring for the Management of Heart Failure in the Outpatient Setting | _ | _ |
| 93278 | Ecg/Signal-Averaged | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.006 | Risk Stratification Tests for Determining Arrhythmias (Signal-Averaged Electrocardiography [SAECG] and Microvolt T-Wave Alternans [MTWA]) | _ | _ |
| 93356 | Myocrd Strain Img Spckl Trck | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RAD601.069 | Myocardial Strain Imaging | 7/15/2022 | _ |
| 93580 | Transcath Closure Of Asd | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.024 | Closure Devices for Patent Foramen Ovale and Atrial Septal Defects | _ | _ |
| 93640 | Evaluation Heart Device | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.003<br>MED202.054 | Implantable Cardioverter Defibrillators<br>Biventricular Pacemakers (Cardiac Resynchronization Therapy) for the Treatment of Heart Failure | _ | _ |
| 93641 | Electrophysiology Evaluation | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.003<br>MED202.054 | Implantable Cardioverter Defibrillators<br>Biventricular Pacemakers (Cardiac Resynchronization Therapy) for the Treatment of Heart Failure | _ | _ |
| 93642 | Electrophysiology Evaluation | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.003<br>MED202.054 | Implantable Cardioverter Defibrillators<br>Biventricular Pacemakers (Cardiac Resynchronization Therapy) for the Treatment of Heart Failure | _ | _ |
| 93644 | Electrophysiology Evaluation | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.003 | Implantable Cardioverter Defibrillators | _ | _ |
| 93660 | Tilt Table Evaluation | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.048 | Tilt Table Testing | _ | _ |
| 93701 | Bioimpedance Cv Analysis | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.058 | Cardiac Hemodynamic Monitoring for the Management of Heart Failure in the Outpatient Setting | _ | _ |
| 93702 | Bis Xtracell Fluid Analysis | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED201.036 | Bioimpedance Devices for Detection and Management of Lymphedema | _ | _ |
| 93740 | Temperature Gradient Studies | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | RAD601.014 | Thermography | _ | _ |
| 93797 | Cardiac Rehab | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE803.023 | Cardiac Rehabilitation (CR) | _ | _ |
| 93798 | Cardiac Rehab/Monitor | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE803.023 | Cardiac Rehabilitation (CR) | _ | _ |
| 93799 | Cardiovascular Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 93886 | Intracranial Complete Study | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 93888 | Intracranial Limited Study | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | _ | _ |
| 93890 | Tcd Vasoreactivity Study | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | _ | _ |
| 93892 | Tcd Emboli Detect W/O Inj | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | _ | _ |
| 93998 | Noninvas Vasc Dx Study Proc | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 94014 | Patient Recorded Spirometry | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | DME101.040 | Home Spirometry | _ | _ |
| 94015 | Patient Recorded Spirometry | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | DME101.040 | Home Spirometry | _ | _ |
| 94016 | Review Patient Spirometry | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | DME101.040 | Home Spirometry | _ | _ |
| 94669 | Mechanical Chest Wall Oscill | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.027 | Airway Clearance Devices | _ | _ |
| 94774 | Ped Home Apnea Rec Compl | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.020 | Home Cardiorespiratory Monitoring | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.020 | Home Cardiorespiratory Monitoring | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.020 | Home Cardiorespiratory Monitoring | _ | _ |
| 94777 | Ped Home Apnea Rec Report | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.020 | Home Cardiorespiratory Monitoring | _ | _ |
| 94799 | Pulmonary Service/Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 95027 | Icut Allergy Titrate-Airborn | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | PSY301.014<br>MED206.001 | Allergy Management<br>Autism Spectrum Disorders (ASD) | _ | _ |
| 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). | PSY301.014<br>MED206.001 | Allergy Management<br>Autism Spectrum Disorders (ASD) | _ | _ |
| 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). | PSY301.014<br>MED206.001 | Allergy Management<br>Autism Spectrum Disorders (ASD) | _ | _ |
| 95199 | Allergy Immunology Services | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 95700 | Eeg Cont Rec W/Vid Eeg Tech | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.008 | Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.008 | Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.008 | Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram | _ | _ |
| 95707 | Eeg W/O Vid 2-12Hr Cont Mntr | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.008 | Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.008 | Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.008 | Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 95710 | Eeg W/O Vid Ea 12-26Hr Cont | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.008 | Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.008 | Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.008 | Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram | _ | _ |
| 95713 | Veeg 2-12 Hr Cont Mntr | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.008 | Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.008 | Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.008 | Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.008 | Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram | _ | _ |
| 95717 | Eeg Phys/Qhp 2-12 Hr W/O Vid | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.008 | Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.008 | Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.008 | Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram | _ | _ |
| 95720 | Eeg Phy/Qhp Ea Incr W/Veeg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.008 | Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.008 | Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.008 | Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram | _ | _ |
| 95723 | Eeg Phy/Qhp>60<84 Hr W/O Vid | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.008 | Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.008 | Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.008 | Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram | _ | _ |
| 95726 | Eeg Phy/Qhp>84 Hr W/Veeg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.008 | Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED204.005<br>MED201.049 | Diagnosis and Medical Management of Sleep Related Breathing Disorders<br>Polysomnography for Non-Respiratory Sleep Disorders | 7/15/2022 | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED204.005<br>MED201.049 | Diagnosis and Medical Management of Sleep Related Breathing Disorders<br>Polysomnography for Non-Respiratory Sleep Disorders | 7/15/2022 | |
| 95803 | Actigraphy Testing | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.048 | Actigraphy | 6/1/2022 | |
| 95805 | Multiple Sleep Latency Test | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED204.005<br>MED201.049 | Polysomnography for Non-Respiratory Sleep Disorders<br>Diagnosis and Medical Management of Obstructive Sleep Apnea Syndrome | | 12/31/2021 |
| 95807 | Sleep Study Attended | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED204.005 | Diagnosis and Medical Management of Obstructive Sleep Apnea Syndrome | | 12/31/2021 |
| 95808 | Polysom Any Age 1-3> Param | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED204.005<br>MED201.049 | Polysomnography for Non-Respiratory Sleep Disorders<br>Diagnosis and Medical Management of Obstructive Sleep Apnea Syndrome | | 12/31/2021 |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED204.005<br>MED201.049 | Diagnosis and Medical Management of Obstructive Sleep Apnea Syndrome<br>Polysomnography for Non-Respiratory Sleep Disorders | 2/15/2022 | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED204.005<br>MED201.049 | Diagnosis and Medical Management of Obstructive Sleep Apnea Syndrome<br>Polysomnography for Non-Respiratory Sleep Disorders | 2/15/2022 | |
| 95905 | Motor &/ Sens Nrve Cndj Test | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED205.033 | Automated Point-of-Care Nerve Conduction Testing | | |
| 95954 | Eeg Monitoring/Giving Drugs | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.008 | Ambulatory or Video Electroencephalogram (EEG) Monitoring, Including Digital Analysis of Electroencephalogram | | |
| 95957 | Eeg Digital Analysis | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.040 | Quantitative Electroencephalography (QEEG) as a Diagnostic Aid for Attention-Deficit Hyperactivity Disorder (ADHD) | | |
| 95961 | Electrode Stimulation Brain | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.011<br>MED205.009 | Topographic Brain Mapping (Quantitative Electroencephalography)<br>Intraoperative Neurophysiologic Monitoring (IONM) | | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.011<br>MED205.009 | Topographic Brain Mapping (Quantitative Electroencephalography)<br>Intraoperative Neurophysiologic Monitoring (IONM) | | |
| 95965 | Meg Spontaneous | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RAD601.038<br>PSY301.014 | Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI)<br>Autism Spectrum Disorders (ASD) | | |
| 95966 | Meg Evoked Single | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RAD601.038<br>PSY301.014 | Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI)<br>Autism Spectrum Disorders (ASD) | | |
| 95967 | Meg Evoked Each Addl | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RAD601.038<br>PSY301.014 | Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI)<br>Autism Spectrum Disorders (ASD) | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR710.018<br>SUR712.025<br>MED205.032<br>SUR712.039<br>SUR712.009 | Sacral Nerve Neuromodulation/Stimulation<br>Deep Brain Stimulation (DBS)<br>Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS)<br>Spinal Cord Stimulation (SCS) and Dorsal Root Ganglion (DRG) Stimulation<br>Responsive Neurostimulation (RNS) for the Treatment of Refractory Focal Epilepsy | _ | _ |
| 95971 | Alys Smpl Sp/Pn Npgt W/Prgrm | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.036<br>SUR712.039<br>SUR710.018<br>SUR712.009<br>SUR712.021 | Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS)<br>Responsive Neurostimulation (RNS) for the Treatment of Refractory Focal Epilepsy<br>Sacral Nerve Neuromodulation/Stimulation<br>Spinal Cord Stimulation (SCS) and Dorsal Root Ganglion (DRG) Stimulation<br>Vagus Nerve Stimulation (VNS) | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.036<br>SUR712.009 | Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS)<br>Spinal Cord Stimulation (SCS) and Dorsal Root Ganglion (DRG) Stimulation | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR712.021 | Vagus Nerve Stimulation (VNS) | _ | _ |
| 95977 | Alys Cplx Cn Npgt Prgrmg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR712.021 | Vagus Nerve Stimulation (VNS) | _ | _ |
| 95980 | Io Anal Gast N-Stim Init | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR709.031 | Gastric Electrical Stimulation (GES) | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR709.031 | Gastric Electrical Stimulation (GES) | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR709.031 | Gastric Electrical Stimulation (GES) | _ | _ |
| 95983 | Alys Brn Npgt Prgrmg 15 Min | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR712.025 | Deep Brain Stimulation (DBS) | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR712.025 | Deep Brain Stimulation (DBS) | _ | _ |
| 95999 | Neurological Procedure | 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE803.009 | Gait Analysis | _ | _ |
| 96001 | Motion Test W/Ft Press Meas | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE803.009 | Gait Analysis | _ | _ |
| 96002 | Dynamic Surface Emg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE803.009<br>MED205.006 | Gait Analysis<br>Surface Scanning Electromyography (EMG) (SEMG), Paraspinal Surface EMG, and Spinoscopy | _ | _ |
| 96003 | Dynamic Fine Wire Emg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE803.009 | Gait Analysis | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 96004 | Phys Review Of Motion Tests | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE803.009<br>MED205.006 | Gait Analysis<br>Surface Scanning<br>Electromyography (EMG) (SEMG), Paraspinal Surface EMG, and Spinoscopy | _ | _ |
| 96379 | Ther/Prop/Diag Inj/Inf Proc | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 96549 | Chemotherapy Unspecified | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 96567 | Pdt Dstr Prmlg Les Skn | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE801.027 | Dermatologic Applications of Photodynamic Therapy (PDT) | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE801.029 | Oncologic Applications of Photodynamic Therapy, Including Barrett Esophagus | _ | _ |
| 96571 | Photodynamic Tx Addl 15 Min | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE801.029 | Oncologic Applications of Photodynamic Therapy, Including Barrett Esophagus | _ | _ |
| 96573 | Pdt Dstr Prmlg Les Phys/Qhp | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE801.027 | Dermatologic Applications of Photodynamic Therapy (PDT) | _ | _ |
| 96574 | Dbrdmt Prmlg Les W/Pdt | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE801.027 | Dermatologic Applications of Photodynamic Therapy (PDT) | _ | _ |
| 96912 | Photochemotherapy With Uv-A | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE801.033 | Phototherapy for Dermatologic Conditions | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE801.033 | Phototherapy for Dermatologic Conditions | _ | _ |
| 96922 | Laser Tx Skin >500 Sq Cm | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE801.033<br>THE801.028 | Phototherapy for Dermatologic Conditions<br>Acne Management | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.023 | Optical Diagnostic Devices for Evaluating Skin Lesions Suspected of Malignancy | _ | _ |
| 96932 | Rcm Celulr Subcelulr Img Skn | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.023 | Optical Diagnostic Devices for Evaluating Skin Lesions Suspected of Malignancy | 10/1/2021 | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.023 | Optical Diagnostic Devices for Evaluating Skin Lesions Suspected of Malignancy | _ | _ |
| 96934 | Rcm Celulr Subcelulr Img Skn | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.023 | Optical Diagnostic Devices for Evaluating Skin Lesions Suspected of Malignancy | _ | _ |
| 96935 | Rcm Celulr Subcelulr Img Skn | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.023 | Optical Diagnostic Devices for Evaluating Skin Lesions Suspected of Malignancy | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.023 | Optical Diagnostic Devices for Evaluating Skin Lesions Suspected of Malignancy | _ | _ |
| 96999 | Dermatological Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| 97012 | Mechanical Traction Therapy | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| 97014 | Electric Stimulation Therapy | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| 97024 | Diathermy Eg Microwave | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE803.008<br>THE803.010<br>SUR705.010 | Non Covered Physical Therapy Services<br>Physical Therapy (PT) and Occupational Therapy (OT) Services<br>Temporomandibular Joint (TMJ) Disorders (TMJD) | 7/1/2021 | _ |
| 97032 | Electrical Stimulation | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| 97039 | Physical Therapy Treatment | 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. | _ | _ | _ | _ |
| 97129 | Ther Ivntj 1St 15 Min | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE803.019 | Cognitive Rehabilitation | _ | 8/31/2022 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 97130 | Ther Ivntj Ea Addl 15 Min | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE803.019 | Cognitive Rehabilitation | _ | _ | |
| 97139 | Physical Medicine Procedure | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ | |
| 97169 | Athletic Trn Eval Low Cmplx | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ | |
| 97170 | Athletic Trn Eval Mod Cmplx | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ | |
| 97171 | Athletic Trn Eval High Cmplx | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ | |
| 97172 | Athletic Trn Re-Eval Plan Cr | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ | |
| 97533 | Sensory Integration | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | PSY301.014<br>THE803.020 | Sensory Integration Therapy and Auditory Integration Therapy Autism Spectrum Disorders (ASD) | _ | _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE803.012 | Work Hardening | _ | _ | |
| 97546 | Work Hardening Add-On | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE803.012 | Work Hardening | _ | _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.036 | Negative Pressure Wound Therapy (NPWT) for the Treatment of Wounds | _ | _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.036 | Negative Pressure Wound Therapy (NPWT) for the Treatment of Wounds | _ | _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.036 | Negative Pressure Wound Therapy (NPWT) for the Treatment of Wounds | _ | _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.036 | Negative Pressure Wound Therapy (NPWT) for the Treatment of Wounds | _ | _ | |
| 97610 | Low Frequency Non-Thermal Us | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | DME101.044 | Ultrasound Wound Therapy | _ | _ | |
| 97799 | Physical Medicine Procedure | 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 BCBSOK. Not subject to utilization review. | _ | _ | _ | | 11/1/2021 |
| 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 BCBSOK. Not subject to utilization review. | _ | _ | _ | | 11/1/2021 |
| 99082 | Unusual Physician Travel | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | | 11/1/2021 |
| 99183 | Hyperbaric Oxygen Therapy | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | THE801.003<br>PSY301.014 | Hyperbaric Oxygen (HBO2) Therapy Autism Spectrum Disorders (ASD) | _ | _ | |
| 99199 | Special Service/Proc/Report | 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. | _ | _ | 1/1/2022 | _ |
| 99425 | BIT095_NON_COVERED.csv | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | 1/1/2022 | _ |
| 99426 | BIT095_NON_COVERED.csv | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | 1/1/2022 | _ |
| 99427 | BIT095_NON_COVERED.csv | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | 1/1/2022 | _ |
| 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. | _ | _ | 1/1/2022 | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | ADM1001.014 | Custodial Care | _ | _ |
| 99512 | Home Visit For Hemodialysis | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE802.002 | Daily Hemodialysis and Hemodialysis in the Home Setting | _ | _ |
| 99600 | Home Visit Nos | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| | | | | | | |
| 0001U | Rbc Dna Hea 35 Ag 11 Bld Grp | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 0005U | Onco Prst8 3 Gene Ur Alg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 0012U | Germln Do Gene Reargmt Detcj | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 0013U | Onc Sld Org Neo Gene Reargmt | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 0014U | Hem Hmtlmf Neo Gene Reargmt | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 0018U | Onc Thyr 10 Microrna Seq Alg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 0042T | Ct Perfusion W/Contrast Cbf | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 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). | MED207.008 | Novel Biomarkers in Risk Assessment and Management of Cardiovascular Disease | _ | _ |
| 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). | SUR705.023 | Computer-Assisted Navigation for Orthopedic Procedures | _ | _ |
| 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). | SUR705.023 | Computer-Assisted Navigation for Orthopedic Procedures | _ | _ |
| 0062U | Ai Sle Igg&Igm Alys 80 Bmrk | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED207.159 | Serum Biomarker Panel Testing for Systemic Lupus Erythematosus and Other Connective Tissue Diseases | _ | _ |
| 0063U | Neuro Autism 32 Amines Alg | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | PSY301.014 | Autism Spectrum Disorders (ASD) | _ | _ |
| 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). | OB401.018 | Tests for Amniotic Protein to Detect Rupture of Membranes (ROM) in Pregnancy | _ | _ |
| 0071T | Us Leiomyomata Ablate <200 | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.022 | Magnetic Resonance-Guided Focused Ultrasound (MRgFUS) | _ | _ |
| 0072T | Us Leiomyomata Ablate >200 | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.022 | Magnetic Resonance-Guided Focused Ultrasound (MRgFUS) | _ | _ |
| 0075T | Perq Stent/Chest Vert Art | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.041 | Endovascular Therapies for Extracranial Vertebral Artery Disease | _ | _ |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 0076T | S&I Stent/Chest Vert Art | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.041 | Endovascular Therapies for Extracranial Vertebral Artery Disease | _ | _ | |
| 0097U | Gi Pathogen 22 Targets | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED207.155 | Gastrointestinal Panels | _ | | 3/31/2022 |
| 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). | SUR713.026 | Retinal Prosthesis | _ | _ | |
| 0101T | Extracorp Shockwv Tx Hi Enrg | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR705.018 | Extracorporeal Shock Wave Therapy for Musculoskeletal Indications and Soft Tissue Injuries | _ | _ | |
| 0102T | Extracorp Shockwv Tx Anesth | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR705.018 | Extracorporeal Shock Wave Therapy for Musculoskeletal Indications and Soft Tissue Injuries | _ | _ | |
| 0106T | Touch Quant Sensory Test | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED205.030 | Quantitative Sensory Testing | _ | _ | |
| 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). | MED201.017 | Gastrointestinal (GI) Motility Measurement | _ | _ | |
| 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). | MED205.030 | Quantitative Sensory Testing | _ | _ | |
| 0108T | Cool Quant Sensory Test | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED205.030 | Quantitative Sensory Testing | _ | _ | |
| 0109T | Heat Quant Sensory Test | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED205.030 | Quantitative Sensory Testing | _ | _ | |
| 0110T | Nos Quant Sensory Test | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED205.030 | Quantitative Sensory Testing | _ | _ | |
| 0139U | Neuro Austm Meas 6 C Metablt | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | PSY301.014 | Autism Spectrum Disorders (ASD) | _ | | 9/30/2021 |
| 0164T | Remove Lumb Artif Disc Addl | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR712.028 | Artificial Intervertebral Disc | _ | | Moved to PA list |
| 0165T | Revise Lumb Artif Disc Addl | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR712.028 | Artificial Intervertebral Disc | _ | | Moved to PA list |
| 0175T | Cad Cxr Remote | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | _ | _ | |
| 0184T | Exc Rectal Tumor Endoscopic | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.040 | Transanal Endoscopic Microsurgery | _ | _ | |
| 0191T | Insert Ant Segment Drain Int | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR713.034 | Aqueous Shunts and Stents for Glaucoma | _ | | 12/31/2021 |
| 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). | OTH903.022 | Ophthalmologic Techniques For Evaluating Glaucoma | _ | _ | |
| 0200T | Perq Sacral Augmt Unilat Inj | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RAD601.056 | Percutaneous Vertebroplasty and Sacroplasty | _ | _ | |
| 0201T | Perq Sacral Augmt Bilat Inj | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RAD601.056 | Percutaneous Vertebroplasty and Sacroplasty | _ | _ | |
| 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). | SUR712.034 | Facet Arthroplasty | _ | _ | |
| 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). | OTH903.025 | Eyelid Thermal Pulsation | _ | _ | |
| 0208T | Audiometry Air Only | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | _ | _ | |
| 0209T | Audiometry Air & Bone | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | _ | _ | |
| 0210T | Speech Audiometry Threshold | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | _ | _ | |

| | | | | | | |
|---|---|---|---|---|---|---|
| 0211T | Speech Audiom Thresh & Recog | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | _ | _ |
| 0213T | Njx Paravert W/Us Cer/Thor | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR702.015 | Facet Joint Injections | _ | Moved to PA list |
| 0214T | Njx Paravert W/Us Cer/Thor | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR702.015 | Facet Joint Injections | _ | Moved to PA list |
| 0215T | Njx Paravert W/Us Cer/Thor | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR702.015 | Facet Joint Injections | _ | Moved to PA list |
| 0216T | Njx Paravert W/Us Lumb/Sac | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR702.015 | Facet Joint Injections | _ | Moved to PA list |
| 0217T | Njx Paravert W/Us Lumb/Sac | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR702.015 | Facet Joint Injections | _ | Moved to PA list |
| 0218T | Njx Paravert W/Us Lumb/Sac | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR702.015 | Facet Joint Injections | _ | Moved to PA list |
| 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). | SUR712.032 | Isolated Facet Joint Fusion | _ | _ |
| 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). | SUR712.032 | Isolated Facet Joint Fusion | _ | _ |
| 0221T | Plmt Post Facet Implt Lumb | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR712.032 | Isolated Facet Joint Fusion | _ | _ |
| 0222T | Plmt Post Facet Implt Addl | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR712.032 | Isolated Facet Joint Fusion | _ | _ |
| 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). | RX501.034<br>RX501.101 | Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions<br>Orthopedic Applications of Platelet-Rich Plasma | _ | _ |
| 0253T | Insert Aqueous Drain Device | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR713.034 | Aqueous Shunts and Stents for Glaucoma | _ | _ |
| 0263T | Im B1 Mrw Cel Ther Cmpl | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR703.051<br>SUR703.048 | Stem Cell Therapy for Peripheral Arterial Disease (PAD)<br>Orthopedic Applications of Stem-Cell Therapy | _ | _ |
| 0264T | Im B1 Mrw Cel Ther Xcl Hrvst | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR703.051<br>SUR703.048 | Stem Cell Therapy for Peripheral Arterial Disease (PAD)<br>Orthopedic Applications of Stem-Cell Therapy | _ | _ |
| 0265T | Im B1 Mrw Cel Ther Hrvst Onl | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR703.051<br>SUR703.048 | Stem Cell Therapy for Peripheral Arterial Disease (PAD)<br>Orthopedic Applications of Stem-Cell Therapy | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE801.034 | Baroreflex Stimulation Devices | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE801.034 | Baroreflex Stimulation Devices | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE801.034 | Baroreflex Stimulation Devices | _ | _ |
| 0269T | Rev/Remvl Crtd Sns Dev Total | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE801.034 | Baroreflex Stimulation Devices | _ | _ |
| 0270T | Rev/Remvl Crtd Sns Dev Lead | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE801.034 | Baroreflex Stimulation Devices | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE801.034 | Baroreflex Stimulation Devices | _ | _ |
| 0272T | Interrogate Crtd Sns Dev | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE801.034 | Baroreflex Stimulation Devices | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE801.034 | Baroreflex Stimulation Devices | _ | _ |
| 0274T | Perq Lamot/Lam Crv/Thrc | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR712.035 | Image-Guided Minimally Invasive Decompression for Spinal Stenosis | 1/1/2023 | _ |
| 0274T | Perq Lamot/Lam Crv/Thrc | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR712.035 | Image-Guided Minimally Invasive Decompression for Spinal Stenosis | _ | Moved to PA list |
| 0274T | Perq Lamot/Lam Crv/Thrc | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR712.035 | Image-Guided Minimally Invasive Decompression for Spinal Stenosis | 10/1/2022 | 12/31/2022 |
| 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). | SUR712.035 | Image-Guided Minimally Invasive Decompression for Spinal Stenosis | 1/1/2023 | _ |
| 0275T | Perq Lamot/Lam Lumbar | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR712.035 | Image-Guided Minimally Invasive Decompression for Spinal Stenosis | _ | Moved to PA list |
| 0275T | Perq Lamot/Lam Lumbar | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR712.035 | Image-Guided Minimally Invasive Decompression for Spinal Stenosis | 10/1/2022 | 12/31/2022 |
| 0278T | Tempr | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED201.040 | Transcutaneous Electrical Stimulation (TENS) and Transcutaneous Electrical Modulation Pain Reprocessing (TEMPR) | _ | _ |
| 0290T | Laser Inc For Pkp/Lkp Recip | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR713.001 | Refractive and Therapeutic Keratoplasty | _ | 12/31/2021 |
| 0308T | Insj Ocular Telescope Prosth | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR713.025 | Intraocular Lens (IOLs) and Implantable Miniature Telescope (IMT) | _ | _ |
| 0312T | Laps Impltj Nstim Vagus | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR701.039 | Vagus Nerve Blocking Therapy for Treatment of Obesity | _ | _ |
| 0313T | Laps Rmvl Nstim Array Vagus | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR701.039 | Vagus Nerve Blocking Therapy for Treatment of Obesity | _ | _ |
| 0314T | Laps Rmvl Vgl Arry&Pls Gen | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR701.039 | Vagus Nerve Blocking Therapy for Treatment of Obesity | _ | _ |
| 0315T | Rmvl Vagus Nerve Pls Gen | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR701.039 | Vagus Nerve Blocking Therapy for Treatment of Obesity | _ | _ |
| 0316T | Replc Vagus Nerve Pls Gen | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR701.039 | Vagus Nerve Blocking Therapy for Treatment of Obesity | _ | _ |
| 0317T | Elec Alys Vagus Nrv Pls Gen | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR701.039 | Vagus Nerve Blocking Therapy for Treatment of Obesity | _ | _ |
| 0323U | Iadna Cns Pthgn Next Gen Seq | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 7/1/2022 | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 7/1/2022 | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 7/1/2022 | _ |
| 0326U | Trgt Gen Seq Alys Pnl 83+ | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 7/1/2022 | _ |
| 0327U | Ftl Aneuploidy Trsmy Dna Seq | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 7/1/2022 | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | OTH903.022 | Ophthalmologic Techniques For Evaluating Glaucoma | _ | _ |
| 0329U | Onc Neo Xomeandtrns Seq Alys | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 7/1/2022 | _ |
| 0330T | Tear Film Img Uni/Bi W/I&R | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | OTH903.025 | Eyelid Thermal Pulsation | _ | _ |
| 0331T | Heart Symp Image Plnr | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RAD604.012 | Myocardial Sympathetic Innervation Imaging in Patients With Heart Failure | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 0331U | Onc Hl Neo Opt Gen Mapping | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 7/1/2022 | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RAD604.012 | Myocardial Sympathetic Innervation Imaging in Patients With Heart Failure | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 10/1/2022 | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 10/1/2022 | |
| 0334U | ONC SLD ORGN TGSA DNA 84/+ | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 10/1/2022 | |
| 0335T | Insj Sinus Tarsi Implant | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR705.027 | Subtalar Arthroereisis (STA) | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 10/1/2022 | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 10/1/2022 | |
| 0337U | ONC PLSM CELL DOandMYELOMA ID | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 10/1/2022 | |
| 0338T | Trnscth Renal Symp Denrv Unl | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR701.030 | Radiofrequency Ablation of the Renal Sympathetic Nerves as a Treatment for Resistant Hypertension | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 10/1/2022 | |
| 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). | SUR701.030 | Radiofrequency Ablation of the Renal Sympathetic Nerves as a Treatment for Resistant Hypertension | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 10/1/2022 | |
| 0340U | ONC PAN CA ALYS MRD PLASMA | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 10/1/2022 | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 10/1/2022 | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE802.003 | Lipid Apheresis | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 10/1/2022 | |
| 0343U | ONC PRST8 XOM ALY 442 SNCRNA | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 10/1/2022 | |
| 0344U | HEP NAFLD SEMIQ EVL 28 LIPID | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 10/1/2022 | |
| 0345T | Transcath Mtral Vlve Repair | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.025 | Transcatheter Mitral Valve Procedures | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 10/1/2022 | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 10/1/2022 | |
| 0347T | Ins Bone Device For Rsa | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | RAD601.054 | Radiostereometric Analysis for Assessment of Orthopedic Implant Position | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 10/1/2022 | |
| 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). | RAD601.054 | Radiostereometric Analysis for Assessment of Orthopedic Implant Position | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 10/1/2022 | |
| 0349T | Rsa Upper Extr Exam | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | RAD601.054 | Radiostereometric Analysis for Assessment of Orthopedic Implant Position | _ | _ |
| 0349U | RX METAB/PCX DNA 27GEN RX IA | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 10/1/2022 | |
| 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). | RAD601.054 | Radiostereometric Analysis for Assessment of Orthopedic Implant Position | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 10/1/2022 | |
| 0351T | Intraop Oct Brst/Node 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). | RAD601.053 | Optical Coherence Tomography of the Breast | _ | _ |
| 0351U | NFCT DS BCT/VIRAL TRAIL IP10 | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 10/1/2022 | |
| 0352T | Oct Brst/Node I&R Per 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). | RAD601.053 | Optical Coherence Tomography of the Breast | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 10/1/2022 | |
| 0353T | Intraop Oct Breast Cavity | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | RAD601.053 | Optical Coherence Tomography of the Breast | _ | _ |
| 0353U | IADNA CHLMYDandGONORR AMP PRB | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 10/1/2022 | |
| 0354U | HPV HI RSK QUAL MRNA E6/E7 | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 10/1/2022 | |
| 0355T | Gi Tract Capsule Endoscopy | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | RAD601.042 | Wireless Capsule Endoscopy (WCE) To Diagnose Disorders of The Small Bowel, Esophagus, And Colon | _ | 12/31/2021 |
| 0356T | Insrt Drug Device For Iop | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | OTH903.024 SUR713.035 | Drug-Eluding Intracanalicular Punctal Plugs and Ocular Inserts Intravitreal, Punctum and Intracameral Implants | _ | 12/31/2021 |
| 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). | RAD601.045 | Whole Body Composition Analysis using Dual X-Ray Absorptiometry (DXA) or Bioelectrical Impedance Analysis (BIA) | _ | _ |
| 0376T | Insert Ant Segment Drain Int | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR713.034 | Aqueous Shunts and Stents for Glaucoma | _ | 12/31/2021 |
| 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). | MED201.044 | Home-Based Monitoring of Visual Field | _ | _ |
| 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). | MED201.044 | Home-Based Monitoring of Visual Field | _ | _ |
| 0394T | Hdr Elctrnc Skn Surf Brchytx | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 0395T | Hdr Elctr Ntrst/Ntrcv Brchtx | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| 0397T | Ercp W/Optical Endomicroscpy | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED201.038 | Confocal Laser Endomicroscopy (CLE) | _ | _ |
| 0398T | Mrgfus Strtctc Les Abltj | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.022 | Magnetic Resonance-Guided Focused Ultrasound (MRgFUS) | _ | 6/30/2022 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 0402T | Colgn Cross-Link Crn Med Sep | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | OTH903.028 | Corneal Collagen Cross-Linking | _ | _ | |
| 0404T | Trnscrv Uterin Fibroid Abltj | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.033 | Laparoscopic, Percutaneous and Transcervical Techniques for the Myolysis of Uterine Fibroids | _ | | 6/30/2022 |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.068 | Cardiac Contractility Modulation (CCM) Device | _ | _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.068 | Cardiac Contractility Modulation (CCM) Device | _ | _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.068 | Cardiac Contractility Modulation (CCM) Device | _ | _ | |
| 0411T | Insj/Rplc Car Modulj Vnt Elt | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.068 | Cardiac Contractility Modulation (CCM) Device | _ | _ | |
| 0412T | Rmvl Cardiac Modulj Pls Gen | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.068 | Cardiac Contractility Modulation (CCM) Device | _ | _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.068 | Cardiac Contractility Modulation (CCM) Device | _ | _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.068 | Cardiac Contractility Modulation (CCM) Device | _ | _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.068 | Cardiac Contractility Modulation (CCM) Device | _ | _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.068 | Cardiac Contractility Modulation (CCM) Device | _ | _ | |
| 0417T | Prgrmg Eval Cardiac Modulj | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.068 | Cardiac Contractility Modulation (CCM) Device | _ | _ | |
| 0418T | Interro Eval Cardiac Modulj | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.068 | Cardiac Contractility Modulation (CCM) Device | _ | _ | |
| 0419T | Dstrj Neurofibroma Xtnsv | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001 | Cosmetic and Reconstructive Procedures | _ | _ | |
| 0420T | Dstrj Neurofibroma Xtnsv | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001 | Cosmetic and Reconstructive Procedures | _ | _ | |
| 0421T | Waterjet Prostate Abltj Cmpl | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR710.024 | Aquablation of the Prostate | _ | _ | |
| 0422T | Tactile Breast Img Uni/Bi | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RAD602.019 | Elastography | _ | _ | |
| 0423T | Assay Secretory Type Ii 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). | MED207.134 | Measurement of Phospholipase A2 in the Assessment of Cardiovascular Risk | _ | | 12/31/2021 |
| 0424T | INSJ/RPLC NSTIM APNEA COMPL | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR701.042 | Phrenic Nerve Stimulation for Central Sleep Apnea | 4/1/2022 | _ | |
| 0424T | Insj/Rplc Nstim Apnea Compl | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.042 | Phrenic Nerve Stimulation for Central Sleep Apnea | _ | | 3/31/2022 |
| 0425T | INSJ/RPLC NSTIM APNEA SEN LD | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR701.042 | Phrenic Nerve Stimulation for Central Sleep Apnea | 4/1/2022 | _ | |
| 0425T | Insj/Rplc Nstim Apnea Sen Ld | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.042 | Phrenic Nerve Stimulation for Central Sleep Apnea | _ | | 3/31/2022 |
| 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). | SUR701.042 | Phrenic Nerve Stimulation for Central Sleep Apnea | 4/1/2022 | _ | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 0426T | Insj/Rplc Nstim Apnea Stm Ld | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.042 | Phrenic Nerve Stimulation for Central Sleep Apnea | _ | | 3/31/2022 |
| 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). | SUR701.042 | Phrenic Nerve Stimulation for Central Sleep Apnea | 4/1/2022 | _ | |
| 0427T | Insj/Rplc Nstim Apnea Pls Gn | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.042 | Phrenic Nerve Stimulation for Central Sleep Apnea | _ | | 3/31/2022 |
| 0428T | RMVL NSTIM APNEA PLS GEN | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR701.042 | Phrenic Nerve Stimulation for Central Sleep Apnea | 4/1/2022 | _ | |
| 0428T | Rmvl Nstim Apnea Pls Gen | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.042 | Phrenic Nerve Stimulation for Central Sleep Apnea | _ | | 3/31/2022 |
| 0429T | RMVL NSTIM APNEA SEN LD | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR701.042 | Phrenic Nerve Stimulation for Central Sleep Apnea | 4/1/2022 | _ | |
| 0429T | Rmvl Nstim Apnea Sen Ld | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.042 | Phrenic Nerve Stimulation for Central Sleep Apnea | _ | | 3/31/2022 |
| 0430T | RMVL NSTIM APNEA STIMJ LD | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR701.042 | Phrenic Nerve Stimulation for Central Sleep Apnea | 4/1/2022 | _ | |
| 0430T | Rmvl Nstim Apnea Stimj Ld | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.042 | Phrenic Nerve Stimulation for Central Sleep Apnea | _ | | 3/31/2022 |
| 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). | SUR701.042 | Phrenic Nerve Stimulation for Central Sleep Apnea | 4/1/2022 | _ | |
| 0431T | Rmvl/Rplc Nstim Apnea Pls Gn | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.042 | Phrenic Nerve Stimulation for Central Sleep Apnea | _ | | 3/31/2022 |
| 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). | SUR701.042 | Phrenic Nerve Stimulation for Central Sleep Apnea | 4/1/2022 | _ | |
| 0432T | Repos Nstim Apnea Stimj Ld | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.042 | Phrenic Nerve Stimulation for Central Sleep Apnea | _ | | 3/31/2022 |
| 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). | SUR701.042 | Phrenic Nerve Stimulation for Central Sleep Apnea | 4/1/2022 | _ | |
| 0433T | Repos Nstim Apnea Sensing Ld | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.042 | Phrenic Nerve Stimulation for Central Sleep Apnea | _ | | 3/31/2022 |
| 0434T | INTERRO EVAL NPGS APNEA | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR701.042 | Phrenic Nerve Stimulation for Central Sleep Apnea | 4/1/2022 | _ | |
| 0434T | Interro Eval Npgs Apnea | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.042 | Phrenic Nerve Stimulation for Central Sleep Apnea | _ | | 3/31/2022 |
| 0435T | PRGRMG EVAL NPGS APNEA 1 SES | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR701.042 | Phrenic Nerve Stimulation for Central Sleep Apnea | 4/1/2022 | _ | |
| 0435T | Prgrmg Eval Npgs Apnea 1 Ses | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.042 | Phrenic Nerve Stimulation for Central Sleep Apnea | _ | | 3/31/2022 |
| 0436T | PRGRMG EVAL NPGS APNEA STUDY | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR701.042 | Phrenic Nerve Stimulation for Central Sleep Apnea | 4/1/2022 | _ | |
| 0436T | Prgrmg Eval Npgs Apnea Study | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.042 | Phrenic Nerve Stimulation for Central Sleep Apnea | _ | | 3/31/2022 |
| 0440T | Abltj Perc Uxtr/Perph Nrv | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.035 | Percutaneous Image-Guided Nerve Cryoablation for Phantom Limb Pain (PLP) | _ | _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.035 | Percutaneous Image-Guided Nerve Cryoablation for Phantom Limb Pain (PLP) | _ | _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.035 | Percutaneous Image-Guided Nerve Cryoablation for Phantom Limb Pain (PLP) | _ | _ | |

| | | | | | | |
|---|---|---|---|---|---|---|
| 0443T | R-T Spctrl Alys Prst8 Tiss | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR717.015 | Saturation Biopsy for Diagnosis, Staging and Management of Prostate Cancer, Including Comprehensive 3D Mapping with Biopsy | _ | _ |
| 0444T | 1St Plmt Drug Elut Oc Ins | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR713.035 | Drug-Eluding Intracanalicular Punctal Plugs and Ocular Inserts | _ | _ |
| 0445T | Sbsqt Plmt Drug Elut Oc Ins | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR713.035 | Drug-Eluding Intracanalicular Punctal Plugs and Ocular Inserts | _ | _ |
| 0449T | Insj Aqueous Drain Dev 1St | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR713.034 | Aqueous Shunts and Stents for Glaucoma | 5/1/2021 | _ |
| 0450T | Insj Aqueous Drain Dev Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR713.034 | Aqueous Shunts and Stents for Glaucoma | _ | _ |
| 0451T | Insj/Rplcmt Aortic Ventr Sys | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | 12/31/2021 |
| 0452T | Insj/Rplcmt Dev Vasc Seal | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | 12/31/2021 |
| 0453T | Insj/Rplcmt Mech-Elec Ntrfce | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | 12/31/2021 |
| 0454T | Insj/Rplcmt Subq Electrode | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | 12/31/2021 |
| 0455T | Remvl Aortic Ventr Cmpl Sys | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | 12/31/2021 |
| 0456T | Remvl Aortic Dev Vasc Seal | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | 12/31/2021 |
| 0457T | Remvl Mech-Elec Skin Ntrfce | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | 12/31/2021 |
| 0458T | Remvl Subq Electrode | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | 12/31/2021 |
| 0459T | Relocaj Rplcmt Aortic Ventr | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | 12/31/2021 |
| 0460T | Repos Aortic Ventr Dev Eltrd | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | 12/31/2021 |
| 0461T | Repos Aortic Contrpulsj Dev | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | 12/31/2021 |
| 0462T | Prgrmg Eval Aortic Ventr Sys | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | 12/31/2021 |
| 0463T | Interrog Aortic Ventr Sys | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | 12/31/2021 |
| 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). | OTH903.033 | Visual Evoked Potential Testing for Glaucoma | _ | _ |
| 0465T | Supchrdl Njx Rx W/O Supply | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | OTH903.035 | Suprachoroidal Injection of a Pharmacologic Agent | _ | _ |
| 0466T | Insj Ch Wal Respir Eltrd/Ra | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR706.009 | Sleep Related Breathing Disorders: Surgical Management | _ | 12/31/2021 |
| 0467T | Revj/Rplmnt Ch Respir Eltrd | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR706.009 | Sleep Related Breathing Disorders: Surgical Management | _ | 12/31/2021 |
| 0468T | Rmvl Ch Wal Respir Eltrd/Ra | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR706.009 | Sleep Related Breathing Disorders: Surgical Management | _ | 12/31/2021 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 0470T | Oct Skn Img Acquisj I&R 1St | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.023 | Optical Diagnostic Devices for Evaluating Skin Lesions Suspected of Malignancy | _ | _ | |
| 0471T | Oct Skn Img Acquisj I&R Addl | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.023 | Optical Diagnostic Devices for Evaluating Skin Lesions Suspected of Malignancy | _ | _ | |
| 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). | SUR713.026 | Retinal Prosthesis | _ | _ | |
| 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). | SUR713.026 | Retinal Prosthesis | _ | _ | |
| 0474T | Insj Aqueous Drg Dev Io Rsvr | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR713.034 | Aqueous Shunts and Stents for Glaucoma | _ | _ | |
| 0479T | Fxjl Abl Lsr 1St 100 Sq Cm | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001 | Cosmetic and Reconstructive Procedures | _ | | 6/30/2022 |
| 0480T | Fxjl Abl Lsr Ea Addl 100Sqcm | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001 | Cosmetic and Reconstructive Procedures | _ | | 6/30/2022 |
| 0481T | Njx Autol Wbc Concentrate | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.034<br>RX501.101 | Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions<br>Orthopedic Applications of Platelet-Rich Plasma | _ | _ | |
| 0483T | Tmvi Percutaneous Approach | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.025 | Transcatheter Mitral Valve Procedures | _ | _ | |
| 0484T | Tmvi Transthoracic Exposure | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.025 | Transcatheter Mitral Valve Procedures | _ | _ | |
| 0485T | Oct Mid Ear I&R Unilateral | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED201.046 | Use of Optical Coherence Tomography (OCT) in the Diagnosis and Treatment of Auditory System Conditions | _ | _ | |
| 0486T | Oct Mid Ear I&R Bilateral | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED201.046 | Use of Optical Coherence Tomography (OCT) in the Diagnosis and Treatment of Auditory System Conditions | _ | _ | |
| 0489T | Regn Cell Tx Scldr Hands | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR703.051 | Orthopedic Applications of Stem Cell Therapy (Including Allografts and Bone Substitutes Used with Autologous Bone Marrow) | 6/1/2022 | _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR703.051 | Orthopedic Applications of Stem Cell Therapy (Including Allografts and Bone Substitutes Used with Autologous Bone Marrow) | 6/1/2022 | _ | |
| 0493T | Near Ifr Spectrsc Of Wounds | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR701.006 | Foot Care Services | _ | _ | |
| 0494T | Prep & Cannulj Cdvr Don Lung | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR703.006<br>SUR703.010 | Lung and Lobar Lung Transplant<br>Heart/Lung Transplant | _ | _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR703.006<br>SUR703.010 | Lung and Lobar Lung Transplant<br>Heart/Lung Transplant | _ | _ | |
| 0496T | Mntr Cdvr Don Lng Ea Addl Hr | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR703.006<br>SUR703.010 | Lung and Lobar Lung Transplant<br>Heart/Lung Transplant | _ | _ | |
| 0499T | Cysto F/Urtl Strix/Stenosis | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR710.026 | Optilume (Drug Coated Balloon) for the Treatment of Urethral Stricture Conditions | _ | _ | |
| 0507T | Near Ifr 2Img Mibmn Glnd I&R | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | OTH903.025 | Eyelid Thermal Pulsation | _ | _ | |
| 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). | RAD601.071 | Pulse-Echo Ultrasound Bone Density Measurement | _ | _ | |

| | | | | | | |
|---|---|---|---|---|---|---|
| 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). | OTH903.036 | Electroretinography (ERG), Multi-focal Electroretinography (mfERG) And Pattern Electroretinography (PERG) | 5/15/2021 | |
| 0510T | Rmvl Sinus Tarsi Implant | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR705.027 | Subtalar Arthroereisis (STA) | | |
| 0511T | Rmvl&Rinsj Sinus Tarsi Implt | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR705.027 | Subtalar Arthroereisis (STA) | | |
| 0512T | Esw Integ Wnd Hlg 1St Wnd | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR705.018 | Extracorporeal Shock Wave Therapy for Musculoskeletal Indications and Soft Tissue Injuries | | |
| 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). | SUR705.018 | Extracorporeal Shock Wave Therapy for Musculoskeletal Indications and Soft Tissue Injuries | | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.054 | Biventricular Pacemakers (Cardiac Resynchronization Therapy) for the Treatment of Heart Failure | | |
| 0516T | Insj Wcs Lv Eltrd Only | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.054 | Biventricular Pacemakers (Cardiac Resynchronization Therapy) for the Treatment of Heart Failure | | |
| 0517T | Insj Wcs Lv Pg Compnt | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.054 | Biventricular Pacemakers (Cardiac Resynchronization Therapy) for the Treatment of Heart Failure | | |
| 0518T | Rmvl Pg Compnt Wcs | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.054 | Biventricular Pacemakers (Cardiac Resynchronization Therapy) for the Treatment of Heart Failure | | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.054 | Biventricular Pacemakers (Cardiac Resynchronization Therapy) for the Treatment of Heart Failure | | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.054 | Biventricular Pacemakers (Cardiac Resynchronization Therapy) for the Treatment of Heart Failure | | |
| 0521T | Interrog Dev Eval Wcs Ip | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.054 | Biventricular Pacemakers (Cardiac Resynchronization Therapy) for the Treatment of Heart Failure | | |
| 0522T | Prgrmg Dev Eval Wcs Ip | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.054 | Biventricular Pacemakers (Cardiac Resynchronization Therapy) for the Treatment of Heart Failure | | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.016 | Varicose Vein Management | | |
| 0525T | Insj/Rplcmt Compl Iims | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.003 | Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems) | | |
| 0526T | Insj/Rplcmt Iims Eltrd Only | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.003 | Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems) | | |
| 0527T | Insj/Rplcmt Iims Implt Mntr | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.003 | Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems) | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| 0528T | Prgrmg Dev Eval Iims Ip | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.003 | Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems) | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.003 | Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems) | _ | _ |
| 0530T | Removal Complete Iims | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.003 | Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems) | _ | _ |
| 0531T | Removal Iims Electrode Only | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.003 | Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems) | _ | _ |
| 0532T | Removal Iims Implt Mntr Only | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.003 | Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems) | _ | _ |
| 0533T | Cont Rec Mvmt Do 6-10 Days | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED205.041 | Physiologic Recording of Movement Disorder Symptoms using Motion Analysis Testing Devices | _ | _ |
| 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). | MED205.041 | Physiologic Recording of Movement Disorder Symptoms using Motion Analysis Testing Devices | _ | _ |
| 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). | MED205.041 | Physiologic Recording of Movement Disorder Symptoms using Motion Analysis Testing Devices | _ | _ |
| 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). | MED205.041 | Physiologic Recording of Movement Disorder Symptoms using Motion Analysis Testing Devices | _ | _ |
| 0537T | Bld Drv T Lymphcyt Car-T Cll | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX502.061 | Oncology Medications | 8/15/2021 | _ |
| 0538T | Bld Drv T Lymphcyt Prep Trns | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX502.061 | Oncology Medications | 8/15/2021 | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX502.061 | Oncology Medications | 8/15/2021 | _ |
| 0540T | Car-T Cll Admn Autologous | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX502.061 | Oncology Medications | 8/15/2021 | _ |
| 0544T | TCAT MV ANNULUS RCNSTJ | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.025 | Baroreflex Stimulation Devices | 10/1/2022 | _ |
| 0547T | B1 Matrl Qual Tst Mcrind Tib | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| 0548T | Tprnl Balo Cntnc Dev 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). | SUR701.036 | Implanted Adjustable Continence Therapy | _ | 12/31/2021 |
| 0549T | Tprnl Balo Cntnc Dev Uni | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR701.036 | Implanted Adjustable Continence Therapy | _ | 12/31/2021 |
| 0550T | Tprnl Balo Cntnc Dev Rmvl Ea | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR701.036 | Implanted Adjustable Continence Therapy | _ | 12/31/2021 |
| 0551T | Tprnl Balo Cntnc Dev Adjmt | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR701.036 | Implanted Adjustable Continence Therapy | _ | 12/31/2021 |

| | | | | | | |
|---|---|---|---|---|---|---|
| 0552T | Low-Level Laser Therapy | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.045<br>MED205.022 | Low-Level and High-Power Laser Therapy<br>Treatment of Tinnitus | _ | _ |
| 0563T | Evac Meibomian Glnd Heat Bi | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | OTH903.025 | Eyelid Thermal Pulsation | _ | _ |
| 0565T | Autol Cell Implt Adps Hrvg | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR703.051 | Orthopedic Applications of Stem Cell Therapy (Including Allograft and Bone Substitute Products Used With Autologous Bone Marrow) | 8/15/2021 | _ |
| 0565T | Autol Cell Implt Adps Hrvg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR703.051 | Orthopedic Applications of Stem Cell Therapy (Including Allograft and Bone Substitute Products Used With Autologous Bone Marrow) | 4/1/2021 | 8/14/2021 |
| 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). | SUR703.051 | Orthopedic Applications of Stem Cell Therapy (Including Allograft and Bone Substitute Products Used With Autologous Bone Marrow) | 8/15/2021 | _ |
| 0566T | Autol Cell Implt Adps Njx | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR703.051 | Orthopedic Applications of Stem Cell Therapy (Including Allograft and Bone Substitute Products Used With Autologous Bone Marrow) | 4/1/2021 | 8/14/2021 |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.035 | Percutaneous Tibial Nerve Stimulation (PTNS) | 3/1/2021 | _ |
| 0588T | Revision/Removal Isdns Ptn | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.035 | Percutaneous Tibial Nerve Stimulation (PTNS) | 3/1/2021 | _ |
| 0589T | Elec Alys Smpl Prgrmg Iins | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.035 | Percutaneous Tibial Nerve Stimulation (PTNS) | 3/1/2021 | _ |
| 0590T | Elec Alys Cplx Prgrmg Iins | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.035 | Percutaneous Tibial Nerve Stimulation (PTNS) | 3/1/2021 | _ |
| 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). | MED201.050 | Transdermal Glomerular Filtration Rate | 4/1/2021 | _ |
| 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). | MED201.050 | Transdermal Glomerular Filtration Rate | 4/1/2021 | _ |
| 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). | ADM1001.032 | Experimental, Investigational and/or Unproven Procedures/Services | 5/15/2021 | _ |
| 0620T | EVASC VEN ARTLZ TIBL/PRNL VN | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | ADM1001.032 | Experimental, Investigational and/or Unproven Procedures/Services | 1/1/2021 | _ |
| 0621T | Trabeculostomy ab interno by laser; | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | ADM1001.032 | Experimental, Investigational and/or Unproven Procedures/Services | 1/1/2021 | _ |
| 0622T | Trabeculostomy ab interno by laser; with use of ophthalmic endoscope | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | ADM1001.032 | Experimental, Investigational and/or Unproven Procedures/Services | 1/1/2021 | _ |
| 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). | ADM1001.032 | Experimental, Investigational and/or Unproven Procedures/Services | 1/1/2021 | _ |
| 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). | ADM1001.032 | Experimental, Investigational and/or Unproven Procedures/Services | 1/1/2021 | _ |
| 0625T | AUTO QUAN C PLAQ CPTR ALYS | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | ADM1001.032 | Experimental, Investigational and/or Unproven Procedures/Services | 1/1/2021 | _ |
| 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). | ADM1001.032 | Experimental, Investigational and/or Unproven Procedures/Services | 1/1/2021 | _ |
| 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). | ADM1001.032 | Experimental, Investigational and/or Unproven Procedures/Services | 1/1/2021 | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 0628T | PERQ NJX ALGC FLUOR LMBR EA | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | ADM1001.032 | Experimental, Investigational and/or Unproven Procedures/Services | 1/1/2021 _ | |
| 0629T | PERQ NJX ALGC CT LMBR 1ST | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | ADM1001.032 | Experimental, Investigational and/or Unproven Procedures/Services | 1/1/2021 _ | |
| 0630T | PERQ NJX ALGC CT LMBR EA | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | ADM1001.032 | Experimental, Investigational and/or Unproven Procedures/Services | 1/1/2021 _ | |
| 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). | ADM1001.032 | Experimental, Investigational and/or Unproven Procedures/Services | 1/1/2021 _ | |
| 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). | ADM1001.032 | Experimental, Investigational and/or Unproven Procedures/Services | 1/1/2021 _ | |
| 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). | ADM1001.032 | Experimental, Investigational and/or Unproven Procedures/Services | 1/1/2021 _ | |
| 0640T | Ncntc Nr Ifr Spctrsc Wnd | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | ADM1001.032 | Experimental, Investigational and/or Unproven Procedures/Services | 7/1/2021 _ | |
| 0641T | Ncntc Nr Ifr Spctrsc Wnd Img | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | ADM1001.032 | Experimental, Investigational and/or Unproven Procedures/Services | 7/1/2021 _ | |
| 0642T | Ncntc Nr Ifr Spctrsc Wnd I&R | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | ADM1001.032 | Experimental, Investigational and/or Unproven Procedures/Services | 7/1/2021 _ | |
| 0643T | Tcat L Ventr Rstrj Dev Implt | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | N/A_Cardiology | #N/A | 7/1/2021 _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | N/A_Cardiology | #N/A | 7/1/2021 _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | N/A_Cardiology | #N/A | 7/1/2021 _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.003 | Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems) | 7/1/2021 _ | |
| 0651T | MAG CTRLD CAPSULE ENDOSCOPY | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | RAD601.042 | Wireless Capsule Endoscopy to Diagnose Disorders of The Small Bowel, Esophagus, and Colon | 1/1/2023 _ | |
| 0651T | MAG CTRLD CAPSULE ENDOSCOPY | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RAD601.042 | Wireless Capsule Endoscopy to Diagnose Disorders of The Small Bowel, Esophagus, and Colon | 11/1/2022 | 12/31/2022 |
| 0656T | Vrt Bdy Tethering Ant <7 Seg | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR705.046 | Vertebral Body Stapling and Vertebral Body Tethering for the Treatment of Scoliosis | 7/1/2021 _ | |
| 0657T | Vrt Bdy Tethering Ant 8+ Seg | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR705.046 | Vertebral Body Stapling and Vertebral Body Tethering for the Treatment of Scoliosis | 7/1/2021 _ | |
| 0658T | Elec Impd Spectrsc 1+Skn Les | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.023 | Optical Diagnostic Devices for Evaluating Skin Lesions Suspected of Malignancy | 10/1/2021 _ | |
| 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). | OB402.023 | Services for Infertility and Recurrent Fetal Loss | 8/15/2021 _ | |
| 0664T | Don Hysterectomy Open Cdvr | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | OB402.023 | Services for Infertility and Recurrent Fetal Loss | 7/1/2021 | 8/14/2021 |
| 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). | OB402.023 | Services for Infertility and Recurrent Fetal Loss | 8/15/2021 _ | |

| | | | | | | |
|---|---|---|---|---|---|---|
| 0665T | Don Hysterectomy Open Liv | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | OB402.023 | Services for Infertility and Recurrent Fetal Loss | 7/1/2021 | 8/14/2021 |
| 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). | OB402.023 | Services for Infertility and Recurrent Fetal Loss | 8/15/2021 _ | |
| 0666T | Don Hysterectomy Laps Liv | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | OB402.023 | Services for Infertility and Recurrent Fetal Loss | 7/1/2021 | 8/14/2021 |
| 0667T | Don Hysterectomy Rcp Uter | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | OB402.023 | Services for Infertility and Recurrent Fetal Loss | 8/15/2021 _ | |
| 0667T | Don Hysterectomy Rcp Uter | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | OB402.023 | Services for Infertility and Recurrent Fetal Loss | 7/1/2021 | 8/14/2021 |
| 0668T | Bkbench Prep Don Uter Algrft | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | OB402.023 | Services for Infertility and Recurrent Fetal Loss | 8/15/2021 _ | |
| 0668T | Bkbench Prep Don Uter Algrft | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | OB402.023 | Services for Infertility and Recurrent Fetal Loss | 7/1/2021 | 8/14/2021 |
| 0669T | Bkbench Rcnstj Don Uter Ven | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | OB402.023 | Services for Infertility and Recurrent Fetal Loss | 8/15/2021 _ | |
| 0669T | Bkbench Rcnstj Don Uter Ven | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | OB402.023 | Services for Infertility and Recurrent Fetal Loss | 7/1/2021 | 8/14/2021 |
| 0670T | Bkbench Rcnstj Don Uter Artl | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | OB402.023 | Services for Infertility and Recurrent Fetal Loss | 8/15/2021 _ | |
| 0670T | Bkbench Rcnstj Don Uter Artl | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | OB402.023 | Services for Infertility and Recurrent Fetal Loss | 7/1/2021 | 8/14/2021 |
| 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). | | | 1/1/2023 | |
| 0672T | NDOVAG CRYG RF REMDL TISS | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | | | 12/1/2022 | 12/31/2022 |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 7/1/2022 _ | |
| 0715T | Perq Trluml Coronry Lithotrp | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 7/1/2022 _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 7/1/2022 _ | |
| 0717T | Adrc Ther Prtl Rc Tear | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 7/1/2022 _ | |
| 0718T | Adrc Ther Prtl Rc Tear Njx | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 7/1/2022 _ | |
| 0719T | Pst Vrt Jt Rplcmt Lmbr 1 Sgm | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 7/1/2022 _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 7/1/2022 _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 7/1/2022 _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 7/1/2022 _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 7/1/2022 _ | |
| 0724T | Qmrcp W/Dx Mri Same Anatomy | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 7/1/2022 _ | |

| | | | | | | |
|---|---|---|---|---|---|---|
| 0725T | Vestibular Dev Impltj Uni | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 7/1/2022 | |
| 0726T | Rmvl Implt Vstibular Dev Uni | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 7/1/2022 | |
| 0727T | Rmvlandrplcmt Implt Vstblr Dev | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 7/1/2022 | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 7/1/2022 | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 7/1/2022 | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 7/1/2022 | |
| 0731T | Augmnt Ai-Based Fcl Phnt A/R | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | 7/1/2022 | |
| 0732T | Immntx Admn Electroporatn Im | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 7/1/2022 | |
| 0733T | Rem Bdyandlmb Knmtc Ther Sply | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 7/1/2022 | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 7/1/2022 | |
| 0735T | Prep Tum Cav Iort Prim Crnot | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 7/1/2022 | |
| 0737T | Xenograft Impltj Artclr Surf | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 7/1/2022 | |
| A0021 | Ambulance Service Outside State Per Mile Transport (Medicaid Only) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| A0080 | Non-Emergency Transportation Per Mile - Vehicle Provided By Volunteer (Individual Or Organization) With No Vested Interest | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| A0090 | Non-Emergency Transportation Per Mile - Vehicle Provided By Individual (Family Member Self Neighbor) With Vested Interest | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| A0100 | Non-Emergency Transportation; Taxi | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| A0110 | Non-Emergency Transportation And Bus Intra Or Inter State Carrier | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| A0120 | Non-Emergency Transportation: Mini-Bus Mountain Area Transports Or Other Transportation Systems | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| A0130 | Non-Emergency Transportation: Wheel-Chair Van | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| A0140 | Non-Emergency Transportation And Air Travel (Private Or Commercial) Intra Or Inter State | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| A0160 | Non-Emergency Transportation: Per Mile - Case Worker Or Social Worker | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| A0170 | Transportation Ancillary: Parking Fees Tolls Other | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| A0180 | Non-Emergency Transportation: Ancillary: Lodging-Recipient | 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. | | | 1/1/2021 | |
| A0200 | Non-Emergency Transportation: Ancillary: Lodging Escort | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| A0210 | Non-Emergency Transportation: Ancillary: Meals-Escort | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| A0420 | Ambulance Waiting Time (Als Or Bls) One Half (1/2) Hour Increments | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| A0426 | Ambulance Service Advanced Life Support Non-Emergency Transport Level 1 (Als 1) | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | ADM1001.005 | Ambulance and Medical Transport Services | | |
| A0427 | Ambulance Service Advanced Life Support Emergency Transport Level 1 (Als1-Emergency) | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | ADM1001.005 | Ambulance and Medical Transport Services | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| A0428 | Ambulance Service Basic Life Support Non-Emergency Transport (Bls) | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | ADM1001.005 | Ambulance and Medical Transport Services | _ | _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | ADM1001.005 | Ambulance and Medical Transport Services | _ | _ | |
| A0431 | Ambulance Service Conventional Air Services Transport One Way (Rotary Wing) | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | ADM1001.005 | Ambulance and Medical Transport Services | _ | _ | |
| A0432 | Paramedic Intercept (Pi) Rural Area Transport Furnished By A Volunteer Ambulance Company Which Is Prohibited By State Law From Billing Third Party Payers | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ | |
| A0435 | Fixed Wing Air Mileage Per Statute Mile | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | ADM1001.005 | Ambulance and Medical Transport Services | _ | _ | |
| A0436 | Rotary 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | ADM1001.005 | Ambulance and Medical Transport Services | _ | _ | |
| A0888 | Noncovered Ambulance Mileage Per Mile (E. G. For Miles Traveled Beyond Closest Appropriate Facility) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ | |
| A0998 | Ambulance Response And Treatment No Transport | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | ADM1001.005 | Ambulance and Medical Transport Services | _ | _ | |
| A0999 | Unlisted Ambulance Service | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ | |
| A2001 | Innovamatrix ac per sq cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 4/15/2022 | _ | |
| A2001 | Innovamatrix ac per sq cm | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 1/1/2022 | 4/14/2022 | |
| A2002 | Mirragen adv wnd mat per sq | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 4/15/2022 | _ | |
| A2002 | Mirragen adv wnd mat per sq | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 1/1/2022 | 4/14/2022 | |
| A2003 | Bio-connekt wound matrix | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | N/A | N/A | 1/1/2022 | 1/1/2022 | |
| A2004 | Xcellistem 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). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 4/15/2022 | _ | |
| A2004 | Xcellistem per sq cm | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 1/1/2022 | 4/14/2022 | |
| A2005 | Microlyte matrix per sq cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 4/15/2022 | _ | |
| A2005 | Microlyte matrix per sq cm | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 1/1/2022 | 4/14/2022 | |
| A2006 | Novosorb synpath per sq cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 4/15/2022 | _ | |
| A2006 | Novosorb synpath per sq cm | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 1/1/2022 | 4/14/2022 | |
| A2007 | Restrata per sq cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 4/15/2022 | _ | |
| A2007 | Restrata per sq cm | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 1/1/2022 | 4/14/2022 | |
| 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). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 4/15/2022 | _ | |
| A2008 | Theragenesis per sq cm | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 1/1/2022 | 4/14/2022 | |
| A2009 | Symphony per sq cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 4/15/2022 | _ | |

| | | | | | | |
|---|---|---|---|---|---|---|
| A2009 | Symphony per sq cm | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 1/1/2022 | 4/14/2022 |
| A2010 | Apis per square centimeter | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 4/15/2022 | _ |
| A2010 | Apis per square centimeter | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 1/1/2022 | 4/14/2022 |
| A2011 | Supra Sdrm Per Sq Cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | n/a | n/a | | |
| 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). | n/a | n/a | | |
| 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). | n/a | n/.a | | |
| A2013 | Innovamatrix Fs Per Sq Cm | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | | |
| A2014 | Omeza collag per 100 mg | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 4/1/2023 | |
| A2014 | Omeza collag per 100 mg | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 10/1/2022 | 3/31/2023 |
| A2015 | Phoenix wnd mtrx per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 4/1/2023 | |
| A2015 | Phoenix wnd mtrx per sq cm | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 10/1/2022 | 3/31/2023 |
| A2016 | Permeaderm b per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 4/1/2023 | |
| A2016 | Permeaderm b per sq cm | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 10/1/2022 | 3/31/2023 |
| A2017 | Permeaderm glove each | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 4/1/2023 | |
| A2017 | Permeaderm glove each | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 10/1/2022 | 3/31/2023 |
| A2018 | Permeaderm c per sq cm | EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP028, which is one of our Clinical Payment and Coding Policy (CPCP). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 4/1/2023 | |
| A2018 | Permeaderm c per sq cm | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 10/1/2022 | 3/31/2023 |
| A4100 | Skin Sub Fda Clrd As Dev Nos | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | | |
| A4238 | Adju Cgm Supply Allowance | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.005 | Glucose Monitoring and Insulin Delivery Devices for Managing Diabetes | | |
| A4267 | Contraceptive Supply Condom Male Each | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | 12/31/2022 |
| A4290 | Sacral Nerve Stimulation Test Lead Each | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR710.018 | Sacral Nerve Neuromodulation/Stimulation | _ | 10/1/2022 |
| A4335 | Incontinence Supply; Miscellaneous | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| A4421 | Ostomy Supply; Miscellaneous | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| A4453 | Rec cath man pump enema repl | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.052 | Bowel Management Devices | 10/1/2021 | _ |
| A4458 | Enema Bag With Tubing Reusable | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| A4520 | Incontinence Garment Any Type (E.G. Brief Diaper) Each | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| A4553 | Non-Disposable Underpads All Sizes | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| A4555 | Electrode/Transducer For Use With Electrical Stimulation Device Used For Cancer Treatment Replacement Only | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.039 | Tumor Treating Fields (TTF) Therapy | _ | _ |
| A4575 | Topical Hyperbaric Oxygen Chamber Disposable | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE801.003<br>PSY301.014 | Hyperbaric Oxygen (HBO2) Therapy<br>Autism Spectrum Disorders (ASD) | 4/1/2022 | _ |
| A4575 | Topical Hyperbaric Oxygen Chamber Disposable | Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). May require Prior Authorization until 03/31/2022 per contract agreement. | THE801.003<br>PSY301.014 | Hyperbaric Oxygen (HBO2) Therapy<br>Autism Spectrum Disorders (ASD) | _ | _ |
| 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 | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | 4/1/2023 | |
| A4596 | Ces system monthly supp | MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for predetermination to avoid post-service review. | SUR702.019 | Cranial Electrotherapy Stimulation and Auricular Electrostimulation | 10/1/2022 | 12/31/2022 |
| A4600 | Sleeve For Intermittent Limb Compression Device Replacement Only Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.060<br>MED202.073 | Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers<br>Postsurgical Outpatient Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis | _ | _ |
| A4630 | Replacement Batteries Medically Necessary Transcutaneous Electrical Stimulator Owned By Patient | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| A4638 | Replacement Battery For Patient-Owned Ear Pulse Generator Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.043 | Transtympanic Micropressure Applications as a Treatment of Meniere Disease | _ | _ |
| A4639 | Replacement Pad For Infrared Heating Pad System Each | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | DME101.045 | Skin Contact Monochromatic Infrared Energy (MIRE) | _ | _ |
| A4641 | Radiopharmaceutical Diagnostic Not Otherwise Classified | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| A4649 | Surgical Supply; Miscellaneous | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| A4660 | Sphygmomanometer/Blood Pressure Apparatus With Cuff And Stethoscope | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| A4663 | Blood Pressure Cuff Only | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| A4913 | Miscellaneous Dialysis Supplies Not Otherwise Specified | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| A4930 | Gloves Sterile Per Pair | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| A4931 | Oral Thermometer Reusable Any Type Each | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| A4932 | Rectal Thermometer Reusable Any Type Each | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| A5507 | For Diabetics Only Not Otherwise Specified Modification (Including Fitting) Of Off-The-Shelf Depth-Inlay Shoe Or Custom-Molded Shoe Per Shoe | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| A6000 | Non-Contact Wound Warming Wound Cover For Use With The Non-Contact Wound Warming Device And Warming Card | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | DME101.050 | Noncontact Normothermic Wound Therapy | _ | _ |
| A6261 | Wound Filler Gel/Paste Per Fluid Ounce Not Otherwise Specified | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| A6262 | Wound Filler Dry Form Per Gram Not Otherwise Specified | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| A6512 | Compression Burn Garment Not Otherwise Classified | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| A6549 | Gradient Compression Stocking/Sleeve Not Otherwise Specified | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| A6550 | Wound Care Set For Negative Pressure Wound Therapy Electrical Pump Includes All Supplies And Accessories | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.036 | Negative Pressure Wound Therapy (NPWT) for the Treatment of Wounds | _ | _ |
| A7020 | Interface For Cough Stimulating Device Includes All Components Replacement Only | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.027 | Airway Clearance Devices | _ | _ |
| A7025 | High Frequency Chest Wall Oscillation System Vest Replacement For Use With Patient Owned Equipment Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.027 | Airway Clearance Devices | _ | _ |
| A7026 | High Frequency Chest Wall Oscillation System Hose Replacement For Use With Patient Owned Equipment Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.027 | Airway Clearance Devices | _ | _ |
| A7047 | Oral Interface Used With Respiratory Suction Pump Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | _ | _ |
| A9150 | Non-Prescription Drugs | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| A9152 | Single Vitamin/Mineral/Trace Element Oral Per Dose Not Otherwise Specified | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| A9153 | Multiple Vitamins With Or Without Minerals And Trace Elements Oral Per Dose Not Otherwise Specified | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| A9180 | Pediculosis (Lice Infestation) Treatment Topical For Administration By Patient/Caretaker | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| A9270 | Non-Covered Item Or Service | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| A9272 | Wound Suction Disposable Includes Dressing All Accessories And Components Any Type Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.036 | Negative Pressure Wound Therapy (NPWT) for the Treatment of Wounds | _ | _ |
| A9273 | Cold Or Hot Fluid Bottle Ice Cap Or Collar Heat And/Or Cold Wrap Any Type | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| A9274 | External Ambulatory Insulin Delivery System Disposable Each Includes All Supplies And Accessories | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.005 | Glucose Monitoring and Insulin Delivery Devices for Managing Diabetes | _ | _ |
| A9279 | Monitoring Feature/Device Stand-Alone Or Integrated Any Type Includes All Accessories Components And Electronics Not Otherwise Classified | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| A9280 | Alert Or Alarm Device Not Otherwise Classified | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| A9281 | Reaching/Grabbing Device Any Type Any Length Each | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| A9285 | Inversion/Eversion Correction 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). | DME103.001 | Orthotics | _ | _ |
| A9291 | Pres Digital Behav Thera Fda | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | PSY302.002 | Digital Health Therapies for Substance Abuse | | |
| A9300 | Exercise Equipment | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| A9515 | Choline C-11 Diagnostic Per Study Dose Up To 20 Millicuries | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | _ | _ |
| A9579 | Injection Gadolinium-Based Magnetic Resonance Contrast Agent Not Otherwise Specified (Nos) Per Ml | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| A9580 | Sodium Fluoride F-18 Diagnostic Per Study Dose Up To 30 Millicuries | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | _ | _ |
| A9582 | Iodine I-123 Iobenguane Diagnostic Per Study Dose Up To 15 Millicuries | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RAD604.012 | Myocardial Sympathetic Innervation Imaging in Patients With Heart Failure | _ | _ |
| A9588 | Fluciclovine F-18 Diagnostic 1 Millicurie | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | _ | _ |
| A9596 | Gallium Illuccix 1 Millicure | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 7/1/2022 | _ |
| A9597 | Positron Emission Tomography Radiopharmaceutical Diagnostic For Tumor Identification Not Otherwise Classified | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| A9598 | Positron Emission Tomography Radiopharmaceutical Diagnostic For Non-Tumor Identification Not Otherwise Classified | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| A9601 | Flortaucipir Inj 1 Millicuri | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 7/1/2022 | _ |
| A9602 | Fluorodopa f-18 diag per mci | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 10/1/2002 | |
| A9606 | Radium Ra-223 Dichloride Therapeutic Per Microcurie | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| A9607 | Lutetium lu 177 vipivotide | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 10/1/2022 | 12/31/2022 |
| A9698 | Non-Radioactive Contrast Imaging Material Not Otherwise Classified Per Study | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| A9699 | Radiopharmaceutical Therapeutic Not Otherwise Classified | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| A9800 | Gallium locametz 1 millicuri | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 10/1/2002 | |
| A9900 | Miscellaneous Dme Supply Accessory And/Or Service Component Of Another Hcpcs Code | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| A9999 | Miscellaneous Dme Supply Or Accessory Not Otherwise Specified | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| B4102 | Enteral Formula For Adults Used To Replace Fluids And Electrolytes (E.G. Clear Liquids) 500 Ml = 1 Unit | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| B4103 | Enteral Formula For Pediatrics Used To Replace Fluids And Electrolytes (E.G. Clear Liquids) 500 Ml = 1 Unit | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| B4104 | Additive For Enteral Formula (E.G. Fiber) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| B4105 | In-Line Cartridge Containing Digestive Enzyme(S) For Enteral Feeding Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.011 | Nutritional Support | _ | _ |
| B4149 | Enteral Formula Manufactured Blenderized Natural Foods With Intact Nutrients Includes Proteins Fats Carbohydrates Vitamins And Minerals May Include Fiber Administered Through An Enteral Feeding Tube 100 Calories = 1 Unit | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| B4150 | Enteral Formula Nutritionally Complete With Intact Nutrients Includes Proteins Fats Carbohydrates Vitamins And Minerals May Include Fiber Administered Through An Enteral Feeding Tube 100 Calories = 1 Unit | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| B4152 | Enteral Formula Nutritionally Complete Calorically Dense (Equal To Or Greater Than 1. 5 Kcal/Ml) With Intact Nutrients Includes Proteins Fats Carbohydrates Vitamins And Minerals May Include Fiber Administered Through An Enteral Feeding Tube 100 Calories = 1 Unit | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| B4153 | Enteral Formula Nutritionally Complete Hydrolyzed Proteins (Amino Acids And Peptide Chain) Includes Fats Carbohydrates Vitamins And Minerals May Include Fiber Administered Through An Enteral Feeding Tube 100 Calories = 1 Unit | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.011 | Nutritional Support | _ | _ |
| B4154 | Enteral Formula Nutritionally Complete For Special Metabolic Needs Excludes Inherited Disease Of Metabolism Includes Altered Composition Of Proteins Fats Carbohydrates Vitamins And/Or 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.011 | Nutritional Support | _ | _ |
| B4155 | Enteral Formula Nutritionally Incomplete/Modular Nutrients Includes Specific Nutrients Carbohydrates (E. G. Glucose Polymers) Proteins/Amino Acids (E. G. Glutamine Arginine) Fat (E. G. Medium Chain Triglycerides) Or Combination Administered Through An Enteral Feeding Tube 100 Calories = 1 Unit | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.011 | Nutritional Support | _ | _ |
| B4157 | Enteral Formula Nutritionally Complete For Special Metabolic Needs For Inherited Disease Of Metabolism Includes Proteins Fats Carbohydrates Vitamins And Minerals May Include Fiber Administered Through An Enteral Feeding Tube 100 Calories = 1 Unit | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.011 | Nutritional Support | _ | _ |
| B4158 | Enteral Formula For Pediatrics Nutritionally Complete With Intact Nutrients Includes Proteins Fats Carbohydrates Vitamins And Minerals May Include Fiber And/Or Iron 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.011 | Nutritional Support | _ | _ |
| B4159 | Enteral Formula For Pediatrics Nutritionally Complete Soy Based With Intact Nutrients Includes Proteins Fats Carbohydrates Vitamins And Minerals May Include Fiber And/Or Iron 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.011 | Nutritional Support | _ | _ |
| B4160 | Enteral Formula For Pediatrics Nutritionally Complete Calorically Dense (Equal To Or Greater Than 0.7 Kcal/Ml) With Intact Nutrients 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.011 | Nutritional Support | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.011 | Nutritional Support | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.011 | Nutritional Support | _ | _ |
| B4164 | Parenteral Nutrition Solution: Carbohydrates (Dextrose) 50% Or Less (500 Ml = 1 Unit) - Homemix | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.011 | Nutritional Support | _ | _ |
| B4168 | Parenteral Nutrition Solution; Amino Acid 3. 5% (500 Ml = 1 Unit) - Homemix | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.011 | Nutritional Support | _ | _ |
| B4172 | Parenteral Nutrition Solution; Amino Acid 5. 5% Through 7% (500 Ml = 1 Unit) - Homemix | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.011 | Nutritional Support | _ | _ |
| B4176 | Parenteral Nutrition Solution; Amino Acid 7% Through 8. 5% (500 Ml = 1 Unit) - Homemix | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.011 | Nutritional Support | _ | _ |
| B4178 | Parenteral Nutrition Solution: Amino Acid Greater Than 8. 5% (500 Ml = 1 Unit) - Homemix | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.011 | Nutritional Support | _ | _ |
| B4180 | Parenteral Nutrition Solution; Carbohydrates (Dextrose) Greater Than 50% (500 Ml=1 Unit) - Homemix | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.011 | Nutritional Support | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.011 | Nutritional Support | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.011 | Nutritional Support | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.011 | Nutritional Support | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.011 | Nutritional Support | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.011 | Nutritional Support | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.011 | Nutritional Support | _ | _ |
| B4222 | Parenteral Nutrition Supply Kit; Home Mix Per Day | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.011 | Nutritional Support | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.011 | Nutritional Support | _ | _ |
| B5000 | Parenteral Nutrition Solution Compounded Amino Acid And Carbohydrates With Electrolytes Trace Elements And Vitamins Including Preparation Any Strength Renal-Aminosyn-Rf Nephramine Renamine-Premix | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.011 | Nutritional Support | _ | _ |
| B5100 | Parenteral Nutrition Solution Compounded Amino Acid And Carbohydrates With Electrolytes Trace Elements And Vitamins Including Preparation Any Strength Hepatic Hepatamine-Premix | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.011 | Nutritional Support | _ | _ |
| B5200 | Parenteral Nutrition Solution Compounded Amino Acid And Carbohydrates With Electrolytes Trace Elements And Vitamins Including Preparation Any Strength Stress-Branch Chain Amino Acids-Freamine-Hbc-Premix | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.011 | Nutritional Support | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| B9004 | Parenteral Nutrition Infusion Pump Portable | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.011 | Nutritional Support | _ | _ |
| B9006 | Parenteral Nutrition Infusion Pump Stationary | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.011 | Nutritional Support | _ | _ |
| B9998 | Noc For Enteral Supplies | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| B9999 | Noc For Parenteral Supplies | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| C1052 | Hemostatic Agent Gi Topic | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | ADM1001.032 | Experimental, Investigational and/or Unproven Procedures/Services | 5/15/2021 | _ |
| C1062 | Intravertebral body fracture augmentation with implant (e.g., metal, polymer) | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RAD601.041 | Percutaneous Balloon Kyphoplasty, Radiofrequency Kyphoplasty, and Mechanical Vertebral Augmentation | 4/1/2021 | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR706.019 | Balloon Ostial Dilation for Treatment of Chronic and Recurrent Acute Rhinosinusitis | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | ADM1001.032 | Experimental, Investigational and/or Unproven Procedures/Services | 7/1/2021 | _ |
| C1764 | Event Recorder Cardiac | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.003 | Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems) | _ | _ |
| C1767 | Generator Neurostimulator (Implantable) Non-Rechargeable | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR710.018<br>SUR701.039<br>SUR712.025<br>SUR709.031<br>SUR712.021<br>SUR712.039<br>SUR712.033<br>SUR712.009 | Sacral Nerve Neuromodulation/Stimulation<br>Gastric Electrical Stimulation (GES)<br>Deep Brain Stimulation (DBS)<br>Vagus Nerve Stimulation (VNS)<br>Spinal Cord Stimulation (SCS) and Dorsal Root Ganglion (DRG) Stimulation<br>Occipital Nerve Stimulation<br>Responsive Neurostimulation (RNS) for the Treatment of Refractory Focal Epilepsy<br>Vagus Nerve Blocking Therapy for Treatment of Obesity | _ | _ |
| C1776 | Joint Device (Implantable) | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR705.021<br>SUR705.024 | Total Ankle Replacement (TAR)<br>Unicondylar Interpositional Spacer as a Treatment of Unicompartmental Arthritis of the Knee | _ | _ |
| C1778 | Lead Neurostimulator | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.036<br>SUR712.009 | Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS)<br>Spinal Cord Stimulation (SCS) and Dorsal Root Ganglion (DRG) Stimulation | _ | _ |
| C1783 | Ocular Implant Aqueous Drainage Assist Device | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR713.034 | Aqueous Shunts and Stents for Glaucoma | _ | _ |
| C1787 | Patient Progr Neurostim | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.036<br>SUR712.009 | Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS)<br>Spinal Cord Stimulation (SCS) and Dorsal Root Ganglion (DRG) Stimulation | _ | _ |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| C1816 | Receiver/Transmitter Neuro | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.036<br>SUR712.009 | Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS) Spinal Cord Stimulation (SCS) and Dorsal Root Ganglion (DRG) Stimulation | _ | _ | |
| C1817 | Septal Defect Imp Sys | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.024 | Closure Devices for Patent Foramen Ovale and Atrial Septal Defects | _ | _ | |
| C1818 | Integrated Keratoprosthesis | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | OTH903.030 | Keratoprosthesis | _ | _ | |
| C1820 | Generator Neurostimulator (Implantable) With Rechargeable Battery And Charging System | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.036<br>SUR712.009 | Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS) Spinal Cord Stimulation (SCS) and Dorsal Root Ganglion (DRG) Stimulation | _ | _ | |
| C1821 | Interspinous Process Distraction Device (Implantable) | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR712.029 | Interspinous Distraction (Spacers) and Interlaminar Stabilization Devices | _ | _ | |
| C1822 | Generator Neurostimulator (Implantable) High Frequency With Rechargeable Battery And Charging System | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.036<br>SUR712.009 | Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS) Spinal Cord Stimulation (SCS) and Dorsal Root Ganglion (DRG) Stimulation | _ | | 12/31/2021 |
| 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). | SUR701.042 | Phrenic Nerve Stimulation for Central Sleep Apnea | 4/1/2022 | _ | |
| C1823 | Generator Neurostimulator (Implantable) Non-Rechargeable With Transvenous Sensing And Stimulation Leads | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.042 | Phrenic Nerve Stimulation for Central Sleep Apnea | _ | | 3/31/2022 |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE801.034 | Baroreflex Stimulation Devices | 2/1/2021 | _ | |
| C1831 | Personalized Interbody Cage | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR712.036 | Lumbar Spinal Fusion | 10/1/2021 | _ | |
| C1832 | Auto cell process sys | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | N/A | N/A | 1/1/2022 | _ | |
| C1833 | BIT047_MEDICAL_POLICY_REVIEW.csv | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.003 | Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems) | 1/1/2022 | _ | |
| C1841 | Retinal Prosthesis Includes All Internal And External Components | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR713.026 | Retinal Prosthesis | _ | _ | |
| C1842 | Retinal Prosthesis Includes All Internal And External Components; Add-On To C1841. | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR713.026 | Retinal Prosthesis | _ | _ | |
| C1883 | Adapt/Ext Pacing/Neuro Lead | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.036<br>SUR712.009 | Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS) Spinal Cord Stimulation (SCS) and Dorsal Root Ganglion (DRG) Stimulation | _ | _ | |
| C1889 | Implantable/Insertable Device Not Otherwise Classified | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ | |
| C2614 | Probe Percutaneous Lumbar Discectomy | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR712.004 | Automated Percutaneous Discectomy and Percutaneous Endoscopic Discectomy | _ | _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RAD601.047 | Radioembolization for Primary and Metastatic Tumors of the Liver | _ | _ | |

| | | | | | | |
|---|---|---|---|---|---|---|
| C2623 | Catheter Transluminal Angioplasty Drug-Coated Non-Laser | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.028<br>SUR701.027<br>SUR701.041 | Endovascular Therapies for Extracranial Vertebral Artery Disease<br>Extracranial Carotid Angioplasty or Stenting<br>Intracranial Stenting or Angioplasty, including Endovascular Procedures | _ | _ |
| C2624 | Implantable Wireless Pulmonary Artery Pressure Sensor With Delivery Catheter Including All System Components | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.058 | Cardiac Hemodynamic Monitoring for the Management of Heart Failure in the Outpatient Setting | _ | _ |
| C2698 | Brachytherapy Source Stranded Not Otherwise Specified Per Source | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| C2699 | Brachytherapy Source Non-Stranded Not Otherwise Specified Per Source | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| C8903 | Magnetic Resonance Imaging With Contrast Breast; Unilateral | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| C8905 | Magnetic Resonance Imaging Without Contrast Followed By With Contrast Breast; Unilateral | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| C8906 | Magnetic Resonance Imaging With Contrast Breast; Bilateral | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| C8908 | Magnetic Resonance Imaging Without Contrast Followed By With Contrast Breast; Bilateral | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| C9075 | Injection Casimersen 10 Mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | N/A | N/A | 7/1/2021 | 9/30/2021 |
| C9076 | Lisocabtagene Car Pos T | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX502.061 | Oncology Medications | 7/1/2021 | 9/30/2021 |
| C9081 | Idecabtagene Car Pos T | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX502.061 | Oncology Medications | 10/1/2021 | 12/31/2021 |
| C9082 | Inj dostarlimab-gxly 100 mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | N/A | N/A | 10/1/2021 | 12/31/2021 |
| C9083 | Inj amivantamab-vmjw 10 mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | N/A | N/A | 10/1/2021 | 12/31/2021 |
| C9084 | Loncastuximab-lpyl 0.1 mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | N/A | N/A | 10/1/2021 | 3/31/2022 |
| C9085 | Inj avalglucosid alfa-ngpt | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.067 | Enzyme-Replacement Therapy for Lysosomal Storage Disorders | 1/1/2022 | 3/31/2022 |
| C9086 | BIT047_MEDICAL_POLICY_REVIEW.csv | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.138 | Anifrolumab-fnia | 1/1/2022 | 3/31/2022 |
| C9092 | Inj. Xipere 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). | OTH903.035 | Suprachoroidal Injection of a Pharmacologic Agent | | 06./30/2022 |
| C9093 | Inj. Susvimo 0.1 Mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | OTH903.041 | Ranibizumab Injections, Implants and Biosimilars | | 06./30/2022 |
| C9094 | Inj Sutimlimab-Jome 10 Mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.087 | FDA-Approved Drugs and Biologicals | 7/1/2022 | _ |
| C9095 | Inj Tebentafusp-Tebn 1 Mcg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 7/1/2022 | _ |
| C9096 | Inj Releuko 1 Mcg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 7/1/2022 | _ |
| C9097 | Inj Faricimab-Svoa 0.1 Mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | OTH903.044 | Faricimab-svoa | 7/1/2022 | _ |
| C9098 | Ciltacabtagene Car Pos T | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 7/1/2022 | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| C9142 | Inj alymsys 10mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 10/1/2022 | 12/31/2022 |
| C9257 | Injection Bevacizumab 0.25 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | OTH903.027<br>OTH903.015<br>OTH903.020 | Intravitreal Angiogenesis Inhibitors for Choroidal Vascular Conditions<br>Intravitreal Angiogenesis Inhibitors for Retinal Vascular Disorders<br>Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV) | _ | _ |
| C9354 | Acellular Pericardial Tissue Matrix Of Non-Human Origin (Veritas) 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). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | _ | _ |
| C9356 | Tendon Porous Matrix Of Cross-Linked Collagen And Glycosaminoglycan Matrix (Tenoglide Tendon Protector Sheet) 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). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | _ | _ |
| 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). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | _ | _ |
| C9359 | Implnt,bon void filler-putty | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR703.051 | Orthopedic Applications of Stem Cell Therapy (Including Allograft and Bone Substitute Products Used With Autologous Bone Marrow) | 4/1/2021 | Moved to PA list |
| C9360 | Dermal Substitute Native Non-Denatured Collagen Neonatal 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). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | _ | _ |
| C9362 | Implnt,bon void filler-strip | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR703.051 | Orthopedic Applications of Stem Cell Therapy (Including Allograft and Bone Substitute Products Used With Autologous Bone Marrow) | 4/1/2021 | Moved to PA list |
| C9363 | Skin substitute (Integra Meshed Bilayer Wound Matrix), per sq cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 5/15/2021 | _ |
| C9364 | Porcine Implant Permacol 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). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | _ | _ |
| C9399 | Unclassified Drugs Or Biologicals | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. May require Prior Authorization based on contract agreement. | _ | _ | _ | _ |
| C9734 | Focused Ultrasound Ablation/Therapeutic Intervention Other Than Uterine Leiomyomata With Magnetic Resonance (Mr) Guidance | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.022 | Magnetic Resonance-Guided Focused Ultrasound (MRgFUS) | _ | _ |
| C9739 | Cystourethroscopy With Insertion Of Transprostatic Implant; 1 To 3 Implants | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR710.023 | Prostatic Urethral Lift (PUL) for the Treatment of Benign Prostatic Hyperplasia (BPH) | _ | _ |
| C9740 | Cystourethroscopy With Insertion Of Transprostatic Implant; 4 Or More Implants | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR710.023 | Prostatic Urethral Lift (PUL) for the Treatment of Benign Prostatic Hyperplasia (BPH) | _ | _ |
| C9752 | Intraosseous Des Lumb/Sacrum | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR702.020 | Intraosseous Radiofrequency Nerve Ablation of the Basivertebral Nerve for the Treatment of Low Back Pain | 7/1/2021 | 12/31/2021 |
| C9753 | Intraosseous Destruct Add'L | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR702.020 | Intraosseous Radiofrequency Nerve Ablation of the Basivertebral Nerve for the Treatment of Low Back Pain | 7/1/2021 | 12/31/2021 |
| C9757 | Spine/lumbar disk surgery | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR705.045 | Annulus Closure After Discectomy | 8/1/2022 | _ |
| C9757 | Spine/lumbar disk surgery | Medical Policy Criteria: Procedure/service may require prior authorization until 07/01/2022. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.045<br>AIM | Annulus Closure After Discectomy<br>AIM Guidelines | 6/15/2021 | 7/31/2022 |
| C9764 | Revasc Intravasc Lithotripsy | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | N/A_Cardiology | N/A | 5/15/2021 | _ |
| C9765 | Revasc Intra Lithotrip-Stent | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | N/A_Cardiology | N/A | 5/15/2021 | _ |
| C9766 | Revasc Intra Lithotrip-Ather | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | N/A_Cardiology | N/A | 5/15/2021 | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| C9767 | Revasc Lithotrip-Stent-Ather | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | N/A_Cardiology | N/A | 5/15/2021 | _ |
| C9768 | Endo us-guide hep porto grad | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR701.043 | Endoscopic Ultrasound-Guided Direct Hepatic Portosystemic Pressure Gradient Measurement | 3/1/2021 | _ |
| C9769 | Cystourethroscopy With Insertion Of Temporary Prostatic Implant/Stent With Fixation/Anchor And Incisional Struts | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.025 | Temporary Prostatic Stent | _ | _ |
| C9770 | Vitrec/mech pars, subret inj | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.098 | Gene Therapy for Inherited Retinal Dystrophy | 4/1/2021 | _ |
| C9771 | Nsl/Sins Cryo Post Nasal Tis | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | ADM1001.032 | Endoscopic Ultrasound-Guided Direct Hepatic Portosystemic Pressure Gradient Measurement | 5/15/2021 | _ |
| C9772 | Revasc Lithotrip Tibi/Perone | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | ADM1001.032 | Experimental, Investigational and/or Unproven Procedures/Services | 8/15/2021 | _ |
| C9772 | Revasc Lithotrip Tibi/Perone | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | ADM1001.032 | Experimental, Investigational and/or Unproven Procedures/Services | 5/15/2021 | 8/14/2021 |
| C9773 | Revasc Lithotr-Stent Tib/Per | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | ADM1001.032 | Experimental, Investigational and/or Unproven Procedures/Services | 8/15/2021 | _ |
| C9773 | Revasc Lithotr-Stent Tib/Per | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | ADM1001.032 | Experimental, Investigational and/or Unproven Procedures/Services | 5/15/2021 | 8/14/2021 |
| C9774 | Revasc Lithotr-Ather Tib/Per | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | ADM1001.032 | Experimental, Investigational and/or Unproven Procedures/Services | 8/15/2021 | _ |
| C9774 | Revasc Lithotr-Ather Tib/Per | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | ADM1001.032 | Experimental, Investigational and/or Unproven Procedures/Services | 5/15/2021 | 8/14/2021 |
| C9775 | Revasc Lith-Sten-Ath Tib/Per | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | ADM1001.032 | Experimental, Investigational and/or Unproven Procedures/Services | 8/15/2021 | _ |
| C9775 | Revasc Lith-Sten-Ath Tib/Per | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | ADM1001.032 | Experimental, Investigational and/or Unproven Procedures/Services | 5/15/2021 | 8/14/2021 |
| C9777 | Esophag Mucosal Integ Add-On | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | ADM1001.032 | EIU Procedures/Services | 8/15/2021 | _ |
| C9780 | Insert cv cath inf & sup app | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | N/A | N/A | 10/1/2021 | _ |
| C9898 | Radiolabeled Product Provided During A Hospital Inpatient Stay | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| C9899 | Implanted Prosthetic Device Payable Only For Inpatients Who Do Not Have Inpatient Coverage | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| D0999 | Unspecified Diagnostic Procedure By Report | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| D1705 | Sarscov2 Covid-19 Vac Rs-Chadox1 5X1010 Vp/.5Ml Im Dose 1 | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | 3/15/2021 | _ |
| 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. | _ | _ | 3/15/2021 | _ |
| D1999 | Unspecified Preventive Procedure By Report | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| D2999 | Unspecified Restorative Procedure By Report | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| D3999 | Unspecified Endodontic Procedure By Report | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| D4999 | Unspecified Periodontal Procedure By Report | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| D5899 | Unspecified Removable Prosthodontic Procedure By Report | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| D5999 | Unspecified Maxillofacial Prosthesis By Report | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| D6199 | Unspecified Implant Procedure By Report | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| D6999 | Unspecified Fixed Prosthodontic Procedure By Report | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| D7999 | Unspecified Oral Surgery Procedure By Report | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| D8999 | Unspecified Orthodontic Procedure By Report | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| D9999 | Unspecified Adjunctive Procedure By Report | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| E0181 | Powered Pressure Reducing Mattress Overlay/Pad Alternating With Pump Includes Heavy Duty | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ | _ |
| E0182 | Pump For Alternating Pressure Pad For Replacement Only | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ | _ |
| E0183 | Press underlay alter w/pump | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 10/1/2022 | |
| E0184 | Dry Pressure Mattress | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ | _ |
| E0186 | Air Pressure Mattress | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ | _ |
| E0187 | Water Pressure Mattress | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ | _ |
| E0190 | Positioning Cushion/Pillow/Wedge Any Shape Or Size Includes All Components And Accessories | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| E0193 | Powered Air Flotation Bed (Low Air Loss Therapy) | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ | _ |
| E0194 | Air Fluidized Bed | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ | _ |
| E0196 | Gel Pressure Mattress | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ | _ |
| E0217 | Water Circulating Heat Pad With Pump | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE801.004 | Heat and Cold Therapy Devices | _ | _ |
| E0218 | Fluid Circulating Cold Pad With Pump Any Type | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE801.004 | Heat and Cold Therapy Devices | _ | _ |
| E0221 | Infrared Heating Pad System | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | DME101.045 | Skin Contact Monochromatic Infrared Energy (MIRE) | _ | _ |
| E0225 | Hydrocollator Unit Includes Pads | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE803.008 | Non Covered Physical Therapy Services | _ | _ |
| E0231 | Non-Contact Wound Warming Device (Temperature Control Unit Ac Adapter And Power Cord) For Use With Warming Card And Wound Cover | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | DME101.050 | Noncontact Normothermic Wound Therapy | _ | _ |
| E0232 | Warming Card For Use With The Non Contact Wound Warming Device And Non Contact Wound Warming Wound Cover | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | DME101.050 | Noncontact Normothermic Wound Therapy | _ | _ |
| E0236 | Pump For Water Circulating Pad | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE801.004 | Heat and Cold Therapy Devices | _ | _ |
| E0239 | Hydrocollator Unit Portable | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE803.008 | Non Covered Physical Therapy Services | _ | _ |
| E0240 | Bath/Shower Chair | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | 5/15/2021 | _ |
| E0241 | Bath Tub Wall Rail | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | 5/15/2021 | _ |
| E0242 | Bath Tub Rail Floor | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | 5/15/2021 | _ |
| E0243 | Toilet Rail | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | 5/15/2021 | _ |
| E0244 | Toilet Seat Raised | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | 5/15/2021 | _ |
| E0245 | Tub Stool Or Bench | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | 5/15/2021 | _ |
| E0246 | Transfer Tub Rail Attachment | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | 5/15/2021 | _ |

| | | | | | |
|---|---|---|---|---|---|
| E0247 | Trans Bench W/Wo Comm Open | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | 5/15/2021 _ |
| E0248 | Hdtrans Bench W/Wo Comm Open | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | 5/15/2021 _ |
| E0249 | Pad For Water Circulating Heat Unit For Replacement Only | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 9/1/2020 _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ _ |
| E0255 | Hospital Bed Variable Height Hi-Lo With Any Type Side Rails With Mattress | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ _ |
| E0256 | Hospital Bed Variable Height Hi-Lo With Any Type Side Rails Without Mattress | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ _ |
| E0260 | Hospital Bed Semi-Electric (Head And Foot Adjustment) With Any Type Side Rails With Mattress | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ _ |
| E0261 | Hospital Bed Semi-Electric (Head And Foot Adjustment) With Any Type Side Rails Without Mattress | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ _ |
| E0265 | Hospital Bed Total Electric (Head Foot And Height Adjustments) With Any Type Side Rails With Mattress | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ _ |
| E0266 | Hospital Bed Total Electric (Head Foot And Height Adjustments) With Any Type Side Rails Without Mattress | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ _ |
| E0270 | Hospital Bed Institutional Type Includes: Oscillating Circulating And Stryker Frame With Mattress | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ _ |
| E0271 | Mattress Innerspring | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ _ |
| E0272 | Mattress Foam Rubber | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ _ |
| E0273 | Bed Board | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ _ |
| E0274 | Over-Bed Table | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ _ |
| E0277 | Powered Pressure-Reducing Air Mattress | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ _ |
| E0280 | Bed Cradle Any Type | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ _ |
| E0290 | Hospital Bed Fixed Height Without Side Rails With Mattress | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ _ |
| E0291 | Hospital Bed Fixed Height Without Side Rails Without Mattress | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ _ |
| E0292 | Hospital Bed Variable Height Hi-Lo Without Side Rails With Mattress | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ _ |
| E0293 | Hospital Bed Variable Height Hi-Lo Without Side Rails Without Mattress | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ _ |
| E0294 | Hospital Bed Semi-Electric (Head And Foot Adjustment) Without Side Rails With Mattress | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ _ |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| E0295 | Hospital Bed Semi-Electric (Head And Foot Adjustment) Without Side Rails Without Mattress | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ | _ | |
| E0296 | Hospital Bed Total Electric (Head Foot And Height Adjustments). Without Side Rails With Mattress | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ | _ | |
| E0297 | Hospital Bed Total Electric (Head Foot And Height Adjustments) Without Side Rails Without Mattress | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ | _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ | _ | |
| E0301 | Hospital Bed Heavy Duty Extra Wide With Weight Capacity Greater Than 350 Pounds But Less Than Or Equal To 600 Pounds With Any Type Side Rails Without Mattress | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ | _ | |
| E0302 | Hospital Bed Extra Heavy Duty Extra Wide With Weight Capacity Greater Than 600 Pounds With Any Type Side Rails Without Mattress | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ | _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ | _ | |
| E0304 | Hospital Bed Extra Heavy Duty Extra Wide With Weight Capacity Greater Than 600 Pounds With Any Type Side Rails With Mattress | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ | _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ | _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ | _ | |
| E0315 | Bed Accessory: Board Table Or Support Device Any Type | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ | _ | |
| E0316 | Safety Enclosure Frame/Canopy For Use With Hospital Bed Any Type | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ | _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ | _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ | _ | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.001 | Hospital Beds and Related Equipment | _ | _ | |
| E0445 | Oximeter Device For Measuring Blood Oxygen Levels Non-Invasively | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | _ | | 3/1/2022 |
| E0446 | Topical Oxygen Delivery System Not Otherwise Specified Includes All Supplies And Accessories | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ | |
| E0470 | Rad W/O Backup Non-Inv Intfc | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED204.005 | Diagnosis and Medical Management of Sleep Related Breathing Disorders | 7/1/2021 | 12/31/2021 | |
| E0471 | Respiratory Assist Device Bi-Level Pressure Capability With Back-Up Rate Feature Used With Noninvasive Interface E. G. Nasal Or Facial Mask (Intermittent Assist Device With Continuous Positive Airway Pressure Device) | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED204.005 | Diagnosis and Medical Management of Obstructive Sleep Apnea Syndrome | _ | | 12/31/2021 |
| E0481 | Intrapulmonary Percussive Ventilation System And Related Accessories | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.027 | Airway Clearance Devices | _ | _ | |
| E0482 | Cough Stimulating Device Alternating Positive And Negative Airway Pressure | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.027 | Airway Clearance Devices | _ | _ | |

| | | | | | | |
|---|---|---|---|---|---|---|
| E0483 | High Frequency Chest Wall Oscillation System Includes All Accessories And Supplies Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.027 | Airway Clearance Devices | _ | _ |
| E0484 | Oscillatory Positive Expiratory Pressure Device Non-Electric Any Type Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.027 | Airway Clearance Devices | _ | _ |
| E0485 | Oral Device/Appliance Used To Reduce Upper Airway Collapsibility Adjustable Or Non-Adjustable Prefabricated Includes Fitting And Adjustment | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED204.005 | Diagnosis and Medical Management of Obstructive Sleep Apnea Syndrome | _ | 12/31/2021 |
| E0486 | Oral Device/Appliance Used To Reduce Upper Airway Collapsibility Adjustable Or Non-Adjustable Custom Fabricated Includes Fitting And Adjustment | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED204.005 | Diagnosis and Medical Management of Obstructive Sleep Apnea Syndrome | _ | 12/31/2021 |
| E0487 | Spirometer Electronic Includes All Accessories | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | DME101.040 | Home Spirometry | _ | _ |
| E0616 | Implantable Cardiac Event Recorder With Memory Activator And Programmer | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.003 | Long-Term Ambulatory Cardiac Monitoring (Outpatient Cardiac Telemetry, Implantable Cardiac Rhythm Event Monitors, and Intracardiac Ischemia Detection Systems) | _ | _ |
| E0617 | External Defibrillator With Integrated Electrocardiogram Analysis | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.021 | Nonwearable Automatic External Defibrillator (AED) for Home Use | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.020 | Home Cardiorespiratory Monitoring | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.020 | Home Cardiorespiratory Monitoring | _ | _ |
| E0620 | Skin Piercing Device For Collection Of Capillary Blood Laser Each | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| E0625 | Patient Lift Bathroom Or Toilet Not Otherwise Classified | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.034 | Lifts and Elevator Systems | _ | _ |
| E0627 | Seat Lift Mechanism Electric Any Type | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.034 | Lifts and Elevator Systems | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.034 | Lifts and Elevator Systems | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.034 | Lifts and Elevator Systems | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.034 | Lifts and Elevator Systems | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.034 | Lifts and Elevator Systems | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.034 | Lifts and Elevator Systems | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.034 | Lifts and Elevator Systems | _ | _ |
| E0640 | Patient Lift Fixed System Includes All Components/Accessories | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.034 | Lifts and Elevator Systems | _ | _ |
| E0641 | Standing Frame/Table System Multi-Position (E.G. Three-Way Stander) Any Size Including Pediatric With Or Without Wheels | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.034 | Lifts and Elevator Systems | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.034 | Lifts and Elevator Systems | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| E0650 | Pneumatic Compressor Non-Segmental Home Model | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.060<br>MED202.073 | Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers<br>Postsurgical Outpatient Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis | _ | _ |
| E0651 | Pneumatic Compressor Segmental Home Model Without Calibrated Gradient Pressure | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.060<br>MED202.073 | Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers<br>Postsurgical Outpatient Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis | _ | _ |
| E0652 | Pneumatic Compressor Segmental Home Model With Calibrated Gradient Pressure | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.060<br>MED202.073 | Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers<br>Postsurgical Outpatient Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis | _ | _ |
| E0655 | Non-Segmental Pneumatic Appliance For Use With Pneumatic Compressor Half Arm | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.060<br>MED202.073 | Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers<br>Postsurgical Outpatient Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis | _ | _ |
| E0656 | Segmental Pneumatic Appliance For Use With Pneumatic Compressor Trunk | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.060<br>MED202.073 | Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers<br>Postsurgical Outpatient Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis | _ | _ |
| E0657 | Segmental Pneumatic Appliance For Use With Pneumatic Compressor Chest | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.060<br>MED202.073 | Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers<br>Postsurgical Outpatient Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis | _ | _ |
| E0660 | Non-Segmental Pneumatic Appliance For Use With Pneumatic Compressor Full Leg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.060<br>MED202.073 | Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers<br>Postsurgical Outpatient Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis | _ | _ |
| E0665 | Non-Segmental Pneumatic Appliance For Use With Pneumatic Compressor Full Arm | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.060<br>MED202.073 | Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers<br>Postsurgical Outpatient Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis | _ | _ |
| E0666 | Non-Segmental Pneumatic Appliance For Use With Pneumatic Compressor Half Leg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.060<br>MED202.073 | Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers<br>Postsurgical Outpatient Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis | _ | _ |
| E0667 | Segmental Pneumatic Appliance For Use With Pneumatic Compressor Full Leg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.060<br>MED202.073 | Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers<br>Postsurgical Outpatient Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| E0668 | Segmental Pneumatic Appliance For Use With Pneumatic Compressor Full Arm | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.060<br>MED202.073 | Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers<br>Postsurgical Outpatient Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis | _ | _ |
| E0669 | Segmental Pneumatic Appliance For Use With Pneumatic Compressor Half Leg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.060<br>MED202.073 | Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers<br>Postsurgical Outpatient Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis | _ | _ |
| E0670 | Segmental Pneumatic Appliance For Use With Pneumatic Compressor Integrated 2 Full Legs And Trunk | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.060<br>MED202.073 | Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers<br>Postsurgical Outpatient Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis | _ | _ |
| E0671 | Segmental Gradient Pressure Pneumatic Appliance Full Leg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.060<br>MED202.073 | Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers<br>Postsurgical Outpatient Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis | _ | _ |
| E0672 | Segmental Gradient Pressure Pneumatic Appliance Full Arm | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.060<br>MED202.073 | Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers<br>Postsurgical Outpatient Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis | _ | _ |
| E0673 | Segmental Gradient Pressure Pneumatic Appliance Half Leg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.060<br>MED202.073 | Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers<br>Postsurgical Outpatient Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis | _ | _ |
| E0675 | Pneumatic Compression Device High Pressure Rapid Inflation/Deflation Cycle For Arterial Insufficiency (Unilateral Or Bilateral System) | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED202.060<br>MED202.073 | Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers<br>Postsurgical Outpatient Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis | _ | _ |
| E0676 | Intermittent Limb Compression Device (Includes All Accessories) Not Otherwise Specified | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.060<br>MED202.073 | Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers<br>Postsurgical Outpatient Use of Limb Compression Devices for Venous Thromboembolism Prophylaxis | _ | _ |
| E0691 | Ultraviolet Light Therapy System Includes Bulbs/Lamps Timer And Eye Protection; Treatment Area 2 Square Feet Or Less | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE801.033 | Phototherapy for Dermatologic Conditions | _ | _ |
| E0692 | Ultraviolet Light Therapy System Panel Includes Bulbs/Lamps Timer And Eye Protection 4 Foot Panel | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE801.033 | Phototherapy for Dermatologic Conditions | _ | _ |
| E0693 | Ultraviolet Light Therapy System Panel Includes Bulbs/Lamps Timer And Eye Protection 6 Foot Panel | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE801.033 | Phototherapy for Dermatologic Conditions | _ | _ |
| E0694 | Ultraviolet Multidirectional Light Therapy System In 6 Foot Cabinet Includes Bulbs/Lamps Timer And Eye Protection | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE801.033 | Phototherapy for Dermatologic Conditions | _ | _ |
| E0705 | Transfer Device Any Type Each | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| E0720 | Transcutaneous Electrical Nerve Stimulation (Tens) Device Two Lead Localized Stimulation | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| E0730 | Transcutaneous Electrical Nerve Stimulation (Tens) Device Four Or More Leads For Multiple Nerve Stimulation | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| E0731 | Form Fitting Conductive Garment For Delivery Of Tens Or Nmes (With Conductive Fibers Separated From The Patient'S Skin By Layers Of Fabric) | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.040 | Transcutaneous Electrical Stimulation (TENS) and Transcutaneous Electrical Modulation Pain Reprocessing (TEMPR) | 1/1/2021 | |
| E0740 | Non-Implanted Pelvic Floor Electrical Stimulator Complete System | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED201.030<br>DME101.037 | Pelvic Floor Stimulation (PFS) as a Treatment of Urinary or Fecal Incontinence<br>Sexual Dysfunctions, Assessment and Treatment | | |
| E0744 | Neuromuscular Stimulator For Scoliosis | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.026 | Surface Electrical Stimulation | | |
| E0745 | Neuromuscular Stimulator Electronic Shock Unit | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | MED201.026<br>SUR710.018 | Sacral Nerve Neuromodulation/Stimulation<br>Surface Electrical Stimulation | | 10/1/2022 |
| E0746 | Electromyography (Emg) Biofeedback Device | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | PSY301.019<br>PSY301.018<br>PSY301.016<br>SUR705.010<br>PSY301.007<br>PSY301.017 | Biofeedback for Miscellaneous Indications<br>Temporomandibular Joint (TMJ) Disorders (TMJD)<br>Biofeedback as a Treatment of Chronic Pain<br>Biofeedback as a Treatment of Headache<br>Biofeedback as a Treatment of Fecal Incontinence or Constipation<br>Biofeedback as a Treatment of Urinary Incontinence | | |
| E0747 | Osteogenesis Stimulator Electrical Non-Invasive Other Than Spinal Applications | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR705.044 | Electrical Bone Growth Stimulation of the Appendicular Skeleton | | |
| E0748 | Osteogenesis Stimulator Electrical Non-Invasive Spinal Applications | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.013 | Electrical Stimulation of the Spine as an Adjunct to Spinal Fusion Procedures | | Moved to PA list |
| E0749 | Osteogenesis Stimulator Electrical Surgically Implanted | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.013<br>SUR705.044 | Electrical Stimulation of the Spine as an Adjunct to Spinal Fusion Procedures<br>Electrical Bone Growth Stimulation of the Appendicular Skeleton | | Moved to PA list |
| E0760 | Osteogenesis Stimulator Low Intensity Ultrasound Non-Invasive | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.030 | Low Intensity Pulsed Ultrasound Fracture Healing Device | | |
| E0761 | Non-Thermal Pulsed High Frequency Radiowaves High Peak Power Electromagnetic Energy Treatment Device | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.027 | Electrostimulation and Electromagnetic Therapy for Treating Wounds | | |
| E0762 | Transcutaneous Electrical Joint Stimulation Device System Includes All Accessories | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED201.042 | Electrical Stimulation for the Treatment of Arthritis | | |
| E0764 | Functional neuromuscularstim | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED201.033 | Functional Neuromuscular Electrical Stimulation | 4/1/2022 | |
| E0764 | Functional neuromuscularstim | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.033 | Functional Neuromuscular Electrical Stimulation | 1/1/2022 | 3/31/2022 |
| E0765 | Fda Approved Nerve Stimulator With Replaceable Batteries For Treatment Of Nausea And Vomiting | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR709.031 | Gastric Electrical Stimulation (GES) | | |
| E0766 | Electrical Stimulation Device Used For Cancer Treatment Includes All Accessories Any Type | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.039 | Tumor Treating Fields (TTF) Therapy | | |
| E0769 | Electrical Stimulation Or Electromagnetic Wound Treatment Device Not Otherwise Classified | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED201.027 | Electrostimulation and Electromagnetic Therapy for Treating Wounds | | |
| E0770 | Functional Electric Stim Nos | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. May require Prior Authorization based on contract agreement until 12/31/2021. | | | | |
| E0781 | Ambulatory Infusion Pump Single Or Multiple Channels Electric Or Battery Operated With Administrative Equipment Worn By Patient | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX504.015<br>MED201.011 | Levodopa-Carbidopa Enteral Suspension (e.g. Duopa) for The Treatment of Parkinson Disease.<br>Nutritional Support | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| E0782 | Infusion Pump Implantable Non-Programmable (Includes All Components E. G. Pump Catheter Connectors Etc. ) | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.008 | Implantable Infusion Pump for Pain and Spasticity | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.008 | Implantable Infusion Pump for Pain and Spasticity | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.005 | Glucose Monitoring and Insulin Delivery Devices for Managing Diabetes | _ | _ |
| E0785 | Implantable Intraspinal (Epidural/Intrathecal) Catheter Used With Implantable Infusion Pump Replacement | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.008 | Implantable Infusion Pump for Pain and Spasticity | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.008 | Implantable Infusion Pump for Pain and Spasticity | _ | _ |
| E0830 | Ambulatory Traction Device All Types Each | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | DME101.041 | Pneumatic Traction and Spinal Unloading Devices | _ | _ |
| E0840 | Traction Frame Attached To Headboard Cervical Traction | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | DME101.046 | Traction Devices for Use in the Home | _ | _ |
| E0849 | Traction Equipment Cervical Free-Standing Stand/Frame Pneumatic Applying Traction Force To Other Than Mandible | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | DME101.046<br>DME101.041 | Pneumatic Traction and Spinal Unloading Devices<br>Traction Devices for Use in the Home | _ | _ |
| E0850 | Traction Stand Free Standing Cervical Traction | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | DME101.046 | Traction Devices for Use in the Home | _ | _ |
| E0855 | Cervical Traction Equipment Not Requiring Additional Stand Or Frame | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | DME101.046 | Traction Devices for Use in the Home | _ | _ |
| E0856 | Cervical Traction Device With Inflatable Air Bladder(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). | DME101.046<br>DME101.041 | Pneumatic Traction and Spinal Unloading Devices<br>Traction Devices for Use in the Home | _ | _ |
| E0860 | Traction Equipment Overdoor Cervical | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | DME101.046 | Traction Devices for Use in the Home | _ | _ |
| E0890 | Traction Frame Attached To Footboard Pelvic Traction | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | DME101.046 | Traction Devices for Use in the Home | _ | _ |
| E0920 | Fracture Frame Attached To Bed Includes Weights | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.046 | Traction Devices for Use in the Home | _ | _ |
| E0930 | Fracture Frame Free Standing Includes Weights | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.046 | Traction Devices for Use in the Home | _ | _ |
| E0935 | Continuous Passive Motion Exercise Device For Use On Knee Only | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.023 | Continuous Passive Motion (CPM) Device | _ | _ |
| E0936 | Continuous Passive Motion Exercise Device For Use Other Than Knee | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | DME101.023 | Continuous Passive Motion (CPM) Device | _ | _ |
| E0941 | Gravity Assisted Traction Device Any Type | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.046 | Traction Devices for Use in the Home | _ | _ |
| E0942 | Cervical Head Harness/Halter | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | DME101.046 | Traction Devices for Use in the Home | _ | _ |
| E0944 | Pelvic Belt/Harness/Boot | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | DME101.046 | Traction Devices for Use in the Home | _ | _ |
| E0946 | Fracture Frame Dual With Cross Bars Attached To Bed (E. G. Balken 4 Poster) | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.046 | Traction Devices for Use in the Home | _ | _ |
| E0947 | Fracture Frame Attachments For Complex Pelvic Traction | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.046 | Traction Devices for Use in the Home | _ | _ |
| E0948 | Fracture Frame Attachments For Complex Cervical Traction | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.046 | Traction Devices for Use in the Home | _ | _ |
| E0950 | Wheelchair Accessory Tray Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E0953 | Wheelchair Accessory Lateral Thigh Or Knee Support Any Type Including Fixed Mounting Hardware Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| E0954 | Wheelchair Accessory Foot Box Any Type Includes Attachment And Mounting Hardware Each Foot | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E0955 | Wheelchair Accessory Headrest Cushioned Any Type Including Fixed Mounting Hardware Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E0969 | Narrowing Device Wheelchair | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E0981 | Wheelchair Accessory Seat Upholstery Replacement Only Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E0982 | Wheelchair Accessory Back Upholstery Replacement Only Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E0983 | Manual Wheelchair Accessory Power Add-On To Convert Manual Wheelchair To Motorized Wheelchair Joystick Control | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E0984 | Manual Wheelchair Accessory Power Add-On To Convert Manual Wheelchair To Motorized Wheelchair Tiller Control | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E0985 | Wheelchair Accessory Seat Lift Mechanism | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E0986 | Manual Wheelchair Accessory Push-Rim Activated Power Assist System | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E0988 | Manual Wheelchair Accessory Lever-Activated Wheel Drive Pair | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E0990 | Wheelchair Accessory Elevating Leg Rest Complete Assembly Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E0992 | Manual Wheelchair Accessory Solid Seat Insert | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1002 | Wheelchair Accessory Power Seating System Tilt Only | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1003 | Wheelchair Accessory Power Seating System Recline Only Without Shear Reduction | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1004 | Wheelchair Accessory Power Seating System Recline Only With Mechanical Shear Reduction | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1005 | Wheelchair Accessory Power Seatng System Recline Only With Power Shear Reduction | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1006 | Wheelchair Accessory Power Seating System Combination Tilt And Recline Without Shear Reduction | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1007 | Wheelchair Accessory Power Seating System Combination Tilt And Recline With Mechanical Shear Reduction | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1008 | Wheelchair Accessory Power Seating System Combination Tilt And Recline With Power Shear Reduction | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1009 | Wheelchair Accessory Addition To Power Seating System Mechanically Linked Leg Elevation System Including Pushrod And Leg Rest Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1010 | Wheelchair Accessory Addition To Power Seating System Power Leg Elevation System Including Leg Rest Pair | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1012 | Wheelchair Accessory Addition To Power Seating System Center Mount Power Elevating Leg Rest/Platform Complete System Any Type Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| E1028 | Wheelchair Accessory Manual Swingaway Retractable Or Removable Mounting Hardware For Joystick Other Control Interface Or Positioning Accessory | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1031 | Rollabout Chair Any And All Types With Castors 5 Or Greater | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1035 | Multi-Positional Patient Transfer System With Integrated Seat Operated By Care Giver Patient Weight Capacity Up To And Including 300 Lbs | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010<br>DME101.034 | Wheelchairs and Accessories<br>Lifts and Elevator Systems | _ | _ |
| E1036 | Multi-Positional Patient Transfer System Extra-Wide With Integrated Seat Operated By Caregiver Patient Weight Capacity Greater Than 300 Lbs | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010<br>DME101.034 | Wheelchairs and Accessories<br>Lifts and Elevator Systems | _ | _ |
| E1037 | Transport Chair Pediatric Size | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1060 | Fully-Reclining Wheelchair Detachable Arms Desk Or Full Length Swing Away Detachable Elevating Legrests | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1070 | Fully-Reclining Wheelchair Detachable Arms (Desk Or Full Length) Swing Away Detachable Footrest | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1083 | Hemi-Wheelchair Fixed Full Length Arms Swing Away Detachable Elevating Leg Rest | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1085 | Hemi-Wheelchair Fixed Full Length Arms Swing Away Detachable Foot Rests | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1087 | High Strength Lightweight 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1089 | High Strength Lightweight Wheelchair Fixed Length Arms Swing Away Detachable Footrest | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1090 | High Strength Lightweight Wheelchair Detachable Arms Desk Or Full Length Swing Away Detachable Foot Rests | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1092 | Wide Heavy Duty Wheel Chair Detachable Arms (Desk Or Full Length) Swing Away Detachable Elevating Leg Rests | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1093 | Wide Heavy Duty Wheelchair Detachable Arms Desk Or Full Length Arms Swing Away Detachable Footrests | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1170 | Amputee 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1171 | Amputee Wheelchair Fixed Full Length Arms Without Footrests Or Legrest | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1172 | Amputee Wheelchair Detachable Arms (Desk Or Full Length) Without Footrests Or Legrest | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1180 | Amputee 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1195 | Heavy Duty 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1200 | Amputee 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1220 | Wheelchair; Specially Sized Or Constructed (Indicate Brand Name Model Number If Any) And Justification | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1221 | Wheelchair With Fixed Arm Footrests | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1225 | Wheelchair Accessory Manual Semi-Reclining Back (Recline Greater Than 15 Degrees But Less Than 80 Degrees) Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1226 | Wheelchair Accessory Manual Fully Reclining Back (Recline Greater Than 80 Degrees) Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1227 | Special Height Arms For Wheelchair | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1228 | Special Back Height For Wheelchair | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1229 | Wheelchair Pediatric Size Not Otherwise Specified | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| E1230 | Power Operated Vehicle (Three Or Four Wheel Nonhighway) Specify Brand Name And Model Number | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1231 | Wheelchair Pediatric Size Tilt-In-Space Rigid Adjustable With Seating System | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1232 | Wheelchair Pediatric Size Tilt-In-Space Folding Adjustable With Seating System | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1234 | Wheelchair Pediatric Size Tilt-In-Space Folding Adjustable Without Seating System | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1235 | Wheelchair Pediatric Size Rigid Adjustable With Seating System | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1236 | Wheelchair Pediatric Size Folding Adjustable With Seating System | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1237 | Wheelchair Pediatric Size Rigid Adjustable Without Seating System | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1238 | Wheelchair Pediatric Size Folding Adjustable Without Seating System | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1239 | Power Wheelchair Pediatric Size Not Otherwise Specified | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1285 | Heavy Duty 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1295 | Heavy Duty Wheelchair Fixed Full Length Arms Elevating Legrest | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1298 | Special Wheelchair Seat Depth And/Or Width By Construction | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E1300 | Whirlpool Portable (Overtub Type) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| E1310 | Whirlpool Non-Portable (Built-In Type) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| E1399 | Durable Medical Equipment Miscellaneous | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| E1629 | BIT047_MEDICAL_POLICY_REVIEW.csv | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE802.002 | Daily Hemodialysis and Hemodialysis in the Home Setting | 1/1/2022 | _ |
| E1632 | Wearable Artificial Kidney | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | THE802.002 | Daily Hemodialysis and Hemodialysis in the Home Setting | 1/1/2023 | _ |
| E1632 | Wearable Artificial Kidney | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE802.002 | Daily Hemodialysis and Hemodialysis in the Home Setting | 7/1/2022 | 12/31/2022 |
| E1699 | Dialysis Equipment Not Otherwise Specified | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| E1700 | Jaw Motion Rehabilitation System | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | DME103.009<br>SUR705.010 | Mechanical Stretching Devices<br>Temporomandibular Joint (TMJ) Disorders (TMJD) | _ | _ |
| E1701 | Replacement Cushions For Jaw Motion Rehabilitation System Pkg. Of 6 | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | DME103.009<br>SUR705.010 | Mechanical Stretching Devices<br>Temporomandibular Joint (TMJ) Disorders (TMJD) | _ | _ |
| E1702 | Replacement Measuring Scales For Jaw Motion Rehabilitation System Pkg. Of 200 | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | DME103.009<br>SUR705.010 | Mechanical Stretching Devices<br>Temporomandibular Joint (TMJ) Disorders (TMJD) | _ | _ |
| E1800 | Dynamic Adjustable Elbow Extension/Flexion Device Includes Soft Interface Material | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME103.009<br>DME103.001 | Mechanical Stretching Devices<br>Orthotics | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME103.009 | Mechanical Stretching Devices | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME103.009<br>DME103.001 | Mechanical Stretching Devices<br>Orthotics | _ | _ |
| E1805 | Dynamic Adjustable Wrist Extension / Flexion Device Includes Soft Interface Material | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME103.009<br>DME103.001 | Mechanical Stretching Devices<br>Orthotics | _ | _ |
| E1806 | Static Progressive Stretch Wrist Device Flexion And/Or Extension With Or Without Range Of Motion Adjustment Includes All Components And Accessories | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME103.009 | Mechanical Stretching Devices | _ | _ |
| E1810 | Dynamic Adjustable Knee Extension / Flexion Device Includes Soft Interface Material | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME103.009<br>DME103.001 | Mechanical Stretching Devices<br>Orthotics | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME103.009 | Mechanical Stretching Devices | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME103.009<br>DME103.001 | Mechanical Stretching Devices<br>Orthotics | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME103.001<br>DME103.009 | Orthotics<br>Mechanical Stretching Devices | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME103.009 | Mechanical Stretching Devices | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME103.009 | Mechanical Stretching Devices | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME103.009<br>DME103.001 | Mechanical Stretching Devices<br>Orthotics | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME103.001<br>DME103.009 | Orthotics<br>Mechanical Stretching Devices | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME103.009<br>DME103.001 | Mechanical Stretching Devices<br>Orthotics | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME103.009<br>DME103.001 | Mechanical Stretching Devices<br>Orthotics | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME103.009 | Mechanical Stretching Devices | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME103.001<br>DME103.009 | Orthotics<br>Mechanical Stretching Devices | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME103.009 | Mechanical Stretching Devices | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.043 | Transtympanic Micropressure Applications as a Treatment of Meniere Disease | _ | _ |
| E2201 | Manual Wheelchair Accessory Nonstandard Seat Frame Width Greater Than Or Equal To 20 Inches And Less Than 24 Inches | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2202 | Manual Wheelchair Accessory Nonstandard Seat Frame Width 24-27 Inches | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2203 | Manual Wheelchair Accessory Nonstandard Seat Frame Depth 20 To Less Than 22 Inches | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2204 | Manual Wheelchair Accessory Nonstandard Seat Frame Depth 22 To 25 Inches | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2206 | Manual Wheelchair Accessory Wheel Lock Assembly Complete Replacement Only Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2207 | Wheelchair Accessory Crutch And Cane Holder Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2209 | Arm Trough With Or Without Hand Support Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2211 | Manual Wheelchair Accessory Pneumatic Propulsion Tire Any Size Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2212 | Manual Wheelchair Accessory Tube For Pneumatic Propulsion Tire Any Size Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2213 | Manual Wheelchair Accessory Insert For Pneumatic Propulsion Tire (Removable) Any Type Any Size Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2214 | Manual Wheelchair Accessory Pneumatic Caster Tire Any Size Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2215 | Manual Wheelchair Accessory Tube For Pneumatic Caster Tire Any Size Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2216 | Manual Wheelchair Accessory Foam Filled Propulsion Tire Any Size Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2217 | Manual Wheelchair Accessory Foam Filled Caster Tire Any Size Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2218 | Manual Wheelchair Accessory Foam Propulsion Tire Any Size Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2219 | Manual Wheelchair Accessory Foam Caster Tire Any Size Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2220 | Manual Wheelchair Accessory Solid (Rubber/Plastic) Propulsion Tire Any Size Replacement Only Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| E2221 | Manual Wheelchair Accessory Solid (Rubber/Plastic) Caster Tire (Removable) Any Size Replacement Only Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2222 | Manual Wheelchair Accessory Solid (Rubber/Plastic) Caster Tire With Integrated Wheel Any Size Replacement Only Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2228 | Manual Wheelchair Accessory Wheel Braking System And Lock Complete Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2230 | Manual Wheelchair Accessory Manual Standing System | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010<br>DME101.034 | Wheelchairs and Accessories<br>Lifts and Elevator Systems | _ | _ |
| E2231 | Manual Wheelchair Accessory Solid Seat Support Base (Replaces Sling Seat) Includes Any Type Mounting Hardware | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010<br>DME101.034 | Wheelchairs and Accessories<br>Lifts and Elevator Systems | _ | _ |
| E2291 | Back Planar For Pediatric Size Wheelchair Including Fixed Attaching Hardware | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2292 | Seat Planar For Pediatric Size Wheelchair Including Fixed Attaching Hardware | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2293 | Back Contoured For Pediatric Size Wheelchair Including Fixed Attaching Hardware | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2294 | Seat Contoured For Pediatric Size Wheelchair Including Fixed Attaching Hardware | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2295 | Manual Wheelchair Accessory For Pediatric Size Wheelchair Dynamic Seating Frame Allows Coordinated Movement Of Multiple Positioning Features | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010<br>DME101.034 | Wheelchairs and Accessories<br>Lifts and Elevator Systems | _ | _ |
| E2300 | Pwr Seat Elevation Sys | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2301 | Pwr Standing | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2310 | Power Wheelchair Accessory Electronic Connection Between Wheelchair Controller And One Power Seating System Motor Including All Related Electronics Indicator Feature Mechanical Function Selection Switch And Fixed Mounting Hardware | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2311 | Power Wheelchair Accessory Electronic Connection Between Wheelchair Controller And Two Or More Power Seating System Motors Including All Related Electronics Indicator Feature Mechanical Function Selection Switch And Fixed Mounting Hardware | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2312 | Power Wheelchair Accessory Hand Or Chin Control Interface Mini-Proportional | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2313 | Power Wheelchair Accessory Harness For Upgrade To Expandable Controller | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2321 | Power Wheelchair Accessory Hand Control Interface Remote Joystick Nonproportional Including All Related Electronics Mechanical Stop Switch And Fixed Mounting Hardware | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2322 | Power Wheelchair Accessory Hand Control Interface Multiple Mechanical Switches Nonproportional Including All Related Electronics Mechanical Stop Switch And Fixed Mounting Hardware | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2323 | Power Wheelchair Accessory Specialty Joystick Handle For Hand Control Interface Prefabricated | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2324 | Power Wheelchair Accessory Chin Cup For Chin Control Interface | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| E2325 | Power Wheelchair Accessory Sip And Puff Interface Nonproportional Including All Related Electronics Mechanical Stop Switch And Manual Swingaway Mounting Hardware | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2326 | Power Wheelchair Accessory Breath Tube Kit For Sip And Puff Interface | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2327 | Power Wheelchair Accessory Head Control Interface Mechanical Proportional Including All Related Electronics Mechanical Direction Change Switch And Fixed Mounting Hardware | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2328 | Power Wheelchair Accessory Head Control Or Extremity Control Interface Electronic Proportional Including All Related Electronics And Fixed Mounting Hardware | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2329 | Power Wheelchair Accessory Head Control Interface Contact Switch Mechanism Nonproportional Including All Related Electronics Mechanical Stop Switch Mechanical Direction Change Switch Head Array And Fixed Mounting Hardware | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2330 | Power Wheelchair Accessory Head Control Interface Proximity Switch Mechanism Nonproportional Including All Related Electronics Mechanical Stop Switch Mechanical Direction Change Switch Head Array And Fixed Mounting Hardware | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2331 | Power Wheelchair Accessory Attendant Control Proportional Including All Related Electronics And Fixed Mounting Hardware | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2340 | Power Wheelchair Accessory Nonstandard Seat Frame Width 20-23 Inches | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2341 | Power Wheelchair Accessory Nonstandard Seat Frame Width 24-27 Inches | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2342 | Power Wheelchair Accessory Nonstandard Seat Frame Depth 20 Or 21 Inches | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2343 | Power Wheelchair Accessory Nonstandard Seat Frame Depth 22-25 Inches | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2351 | Power Wheelchair Accessory Electronic Interface To Operate Speech Generating Device Using Power Wheelchair Control Interface | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2358 | Power Wheelchair Accessory Group 34 Non-Sealed Lead Acid Battery Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2359 | Power Wheelchair Accessory Group 34 Sealed Lead Acid Battery Each (E.G. Gel Cell Absorbed Glassmat) | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2360 | Power Wheelchair Accessory 22 Nf Non-Sealed Lead Acid Battery Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2361 | Power Wheelchair Accessory 22Nf Sealed Lead Acid Battery Each (E. G. Gel Cell Absorbed Glassmat) | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2362 | Power Wheelchair Accessory Group 24 Non-Sealed Lead Acid Battery Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2363 | Power Wheelchair Accessory Group 24 Sealed Lead Acid Battery Each (E. G. Gel Cell Absorbed Glassmat) | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2364 | Power Wheelchair Accessory U-1 Non-Sealed Lead Acid Battery Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2365 | Power Wheelchair Accessory U-1 Sealed Lead Acid Battery Each (E. G. Gel Cell Absorbed Glassmat) | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| E2366 | Power Wheelchair Accessory Battery Charger Single Mode For Use With Only One Battery Type Sealed Or Non-Sealed Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2367 | Power Wheelchair Accessory Battery Charger Dual Mode For Use With Either Battery Type Sealed Or Non-Sealed Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2371 | Power Wheelchair Accessory Group 27 Sealed Lead Acid Battery (E.G. Gel Cell Absorbed Glassmat) Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2372 | Power Wheelchair Accessory Group 27 Non-Sealed Lead Acid Battery Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2373 | Power Wheelchair Accessory Hand Or Chin Control Interface Compact Remote Joystick Proportional Including Fixed Mounting Hardware | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2374 | Power Wheelchair Accessory Hand Or Chin Control Interface Standard Remote Joystick (Not Including Controller) Proportional Including All Related Electronics And Fixed Mounting Hardware Replacement Only | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2375 | Power Wheelchair Accessory Non-Expandable Controller Including All Related Electronics And Mounting Hardware Replacement Only | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2376 | Power Wheelchair Accessory Expandable Controller Including All Related Electronics And Mounting Hardware Replacement Only | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2377 | Power Wheelchair Accessory Expandable Controller Including All Related Electronics And Mounting Hardware Upgrade Provided At Initial Issue | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2397 | Power Wheelchair Accessory Lithium-Based Battery Each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2402 | Negative Pressure Wound Therapy Electrical Pump Stationary Or Portable | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.036 | Negative Pressure Wound Therapy (NPWT) for the Treatment of Wounds | _ | _ |
| E2500 | Speech Generating Device Digitized Speech Using Pre-Recorded Messages Less Than Or Equal To 8 Minutes Recording Time | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.009 | Speech Generating Devices (SGD) | _ | _ |
| E2502 | Speech Generating Device Digitized Speech Using Pre-Recorded Messages Greater Than 8 Minutes But Less Than Or Equal To 20 Minutes Recording Time | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.009 | Speech Generating Devices (SGD) | _ | _ |
| E2504 | Speech Generating Device Digitized Speech Using Pre-Recorded Messages Greater Than 20 Minutes But Less Than Or Equal To 40 Minutes Recording Time | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.009 | Speech Generating Devices (SGD) | _ | _ |
| E2506 | Speech Generating Device Digitized Speech Using Pre-Recorded Messages Greater Than 40 Minutes Recording Time | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.009 | Speech Generating Devices (SGD) | _ | _ |
| E2508 | Speech Generating Device Synthesized Speech Requiring Message Formulation By Spelling And Access By Physical Contact With The Device | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.009 | Speech Generating Devices (SGD) | _ | _ |
| E2510 | Speech Generating Device Synthesized Speech Permitting Multiple Methods Of Message Formulation And Multiple Methods Of Device Access | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.009 | Speech Generating Devices (SGD) | _ | _ |
| E2511 | Speech Generating Software Program For Personal Computer Or Personal Digital Assistant | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.009 | Speech Generating Devices (SGD) | _ | _ |
| E2512 | Accessory For Speech Generating Device Mounting System | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.009 | Speech Generating Devices (SGD) | _ | _ |
| E2599 | Accessory For Speech Generating Device Not Otherwise Classified | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.009 | Speech Generating Devices (SGD) | _ | _ |
| E2601 | General Use Wheelchair Seat Cushion Width Less Than 22 Inches Any Depth | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2602 | General Use Wheelchair Seat Cushion Width 22 Inches Or Greater Any Depth | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| E2603 | Skin Protection Wheelchair Seat Cushion Width Less Than 22 Inches Any Depth | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2604 | Skin Protection Wheelchair Seat Cushion Width 22 Inches Or Greater Any Depth | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2605 | Positioning Wheelchair Seat Cushion Width Less Than 22 Inches Any Depth | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2606 | Positioning Wheelchair Seat Cushion Width 22 Inches Or Greater Any Depth | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2607 | Skin Protection And Positioning Wheelchair Seat Cushion Width Less Than 22 Inches Any Depth | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2608 | Skin Protection And Positioning Wheelchair Seat Cushion Width 22 Inches Or Greater Any Depth | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2609 | Custom Fabricated Wheelchair Seat Cushion Any Size | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2610 | Wheelchair Seat Cushion Powered | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2611 | General Use Wheelchair Back Cushion Width Less Than 22 Inches Any Height Including Any Type Mounting Hardware | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2612 | General Use Wheelchair Back Cushion Width 22 Inches Or Greater Any Height Including Any Type Mounting Hardware | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2613 | Positioning Wheelchair Back Cushion Posterior Width Less Than 22 Inches Any Height Including Any Type Mounting Hardware | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2614 | Positioning Wheelchair Back Cushion Posterior Width 22 Inches Or Greater Any Height Including Any Type Mounting Hardware | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2615 | Positioning Wheelchair Back Cushion Posterior-Lateral Width Less Than 22 Inches Any Height Including Any Type Mounting Hardware | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2616 | Positioning Wheelchair Back Cushion Posterior-Lateral Width 22 Inches Or Greater Any Height Including Any Type Mounting Hardware | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2617 | Custom Fabricated Wheelchair Back Cushion Any Size Including Any Type Mounting Hardware | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2620 | Positioning Wheelchair Back Cushion Planar Back With Lateral Supports Width Less Than 22 Inches Any Height Including Any Type Mounting Hardware | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2621 | Positioning Wheelchair Back Cushion Planar Back With Lateral Supports Width 22 Inches Or Greater Any Height Including Any Type Mounting Hardware | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2622 | Skin Protection Wheelchair Seat Cushion Adjustable Width Less Than 22 Inches Any Depth | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2623 | Skin Protection Wheelchair Seat Cushion Adjustable Width 22 Inches Or Greater Any Depth | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2624 | Skin Protection And Positioning Wheelchair Seat Cushion Adjustable Width Less Than 22 Inches Any Depth | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2625 | Skin Protection And Positioning Wheelchair Seat Cushion Adjustable Width 22 Inches Or Greater Any Depth | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2626 | Wheelchair Accessory Shoulder Elbow Mobile Arm Support Attached To Wheelchair Balanced Adjustable | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| E2627 | Wheelchair Accessory Shoulder Elbow Mobile Arm Support Attached To Wheelchair Balanced Adjustable Rancho Type | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2628 | Wheelchair Accessory Shoulder Elbow Mobile Arm Support Attached To Wheelchair Balanced Reclining | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2629 | Wheelchair Accessory Shoulder Elbow Mobile Arm Support Attached To Wheelchair Balanced Friction Arm Support (Friction Dampening To Proximal And Distal Joints) | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2630 | Wheelchair Accessory Shoulder Elbow Mobile Arm Support Monosuspension Arm And Hand Support Overhead Elbow Forearm Hand Sling Support Yoke Type Suspension Support | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2631 | Wheelchair Accessory Addition To Mobile Arm Support Elevating Proximal Arm | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2632 | Wheelchair Accessory Addition To Mobile Arm Support Offset Or Lateral Rocker Arm With Elastic Balance Control | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| E2633 | Wheelchair Accessory Addition To Mobile Arm Support Supinator | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| G0127 | Trimming Of Dystrophic Nails Any Number | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.006 | Foot Care Services | _ | _ |
| G0151 | Services Performed By A Qualified Physical Therapist In The Home Health Or Hospice Setting Each 15 Minutes | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | PSY301.014<br>THE803.010 | Physical Therapy (PT) and Occupational Therapy (OT) Services<br>Autism Spectrum Disorders (ASD) | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | PSY301.014<br>THE803.010 | Physical Therapy (PT) and Occupational Therapy (OT) Services<br>Autism Spectrum Disorders (ASD) | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | PSY301.014<br>THE803.014 | Speech-Language Therapy (SLT)<br>Autism Spectrum Disorders (ASD) | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | PSY301.014<br>THE803.010 | Physical Therapy (PT) and Occupational Therapy (OT) Services<br>Autism Spectrum Disorders (ASD) | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | PSY301.014<br>THE803.010 | Physical Therapy (PT) and Occupational Therapy (OT) Services<br>Autism Spectrum Disorders (ASD) | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | PSY301.014<br>THE803.010 | Physical Therapy (PT) and Occupational Therapy (OT) Services<br>Autism Spectrum Disorders (ASD) | _ | _ |
| G0160 | Services Performed By A Qualified Occupational Therapist In The Home Health Setting In The Establishment Or Delivery Of A Safe And Effective Occupational Therapy Maintenance Program Each 15 Minutes | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | PSY301.014<br>THE803.010 | Physical Therapy (PT) and Occupational Therapy (OT) Services<br>Autism Spectrum Disorders (ASD) | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | PSY301.014<br>THE803.014 | Speech-Language Therapy (SLT)<br>Autism Spectrum Disorders (ASD) | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.050 | Enhanced External Counterpulsation (EECP) | _ | _ |
| G0176 | Activity Therapy Such As Music Dance Art Or Play Therapies Not For Recreation 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | PSY301.014 | Autism Spectrum Disorders (ASD) | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | PSY301.014 | Autism Spectrum Disorders (ASD) | _ | _ |
| G0219 | Pet Imaging Whole Body; Melanoma For Non-Covered Indications | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| G0235 | Pet Imaging Any Site Not Otherwise Specified | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. May require Prior Authorization based on contract agreement. | AIM Guidelines | _ | _ | _ |
| G0252 | Pet Imaging Full And Partial-Ring Pet Scanners Only For Initial Diagnosis Of Breast Cancer And/Or Surgical Planning For Breast Cancer (E. G. Initial Staging Of Axillary Lymph Nodes) | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| G0255 | Current Perception Threshold/Sensory Nerve Conduction Test (Snct) Per Limb Any Nerve | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED205.030 MED205.033 | Automated Point-of-Care Nerve Conduction Testing Quantitative Sensory Testing | _ | _ |
| G0276 | Blinded Procedure For Lumbar Stenosis Percutaneous Image-Guided Lumbar Decompression (Pild) Or Placebo-Control Performed In An Approved Coverage With Evidence Development (Ced) Clinical Trial | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G0277 | Hyperbaric Oxygen Under Pressure Full Body Chamber Per 30 Minute Interval | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | THE801.003 | Hyperbaric Oxygen (HBO2) Therapy | _ | _ |
| G0281 | Electrical Stimulation (Unattended) To One Or More Areas For Chronic Stage Iii And Stage Iv Pressure Ulcers Arterial Ulcers Diabetic Ulcers And Venous Statsis Ulcers Not Demonstrating Measurable Signs Of Healing After 30 Days Of Conventional Care As Part Of A Therapy Plan Of Care | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED201.027 | Electrostimulation and Electromagnetic Therapy for Treating Wounds | _ | _ |
| G0282 | Electrical Stimulation (Unattended) To One Or More Areas For Wound Care Other Than Described In G0281 | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED201.027 | Electrostimulation and Electromagnetic Therapy for Treating Wounds | _ | _ |
| G0283 | Electrical Stimulation (Unattended) To One Or More Areas For Indication(S) Other Than Wound Care As Part Of A Therapy Plan Of Care | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G0293 | Noncovered Surgical Procedure(S) Using Conscious Sedation Regional General Or Spinal Anesthesia In A Medicare Qualifying Clinical Trial Per Day | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G0294 | Noncovered Procedure(S) Using Either No Anesthesia Or Local Anesthesia Only In A Medicare Qualifying Clinical Trial Per Day | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G0295 | Electromagnetic Therapy To One Or More Areas For Wound Care Other Than Described In G0329 Or For Other Uses | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | THE803.008 MED201.027 | Electrostimulation and Electromagnetic Therapy for Treating Wounds Non Covered Physical Therapy Services | _ | _ |
| G0302 | Pre-Operative Pulmonary Surgery Services For Preparation For Lvrs Complete Course Of Services To Include A Minimum Of 16 Days Of Services | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE803.025 | Pulmonary Rehabilitation | _ | _ |
| G0303 | Pre-Operative Pulmonary Surgery Services For Preparation For Lvrs 10 To 15 Days Of Services | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE803.025 | Pulmonary Rehabilitation | _ | _ |
| G0304 | Pre-Operative Pulmonary Surgery Services For Preparation For Lvrs 1 To 9 Days Of Services | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE803.025 | Pulmonary Rehabilitation | _ | _ |
| G0305 | Post-Discharge Pulmonary Surgery Services After Lvrs Minimum Of 6 Days Of Services | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE803.025 | Pulmonary Rehabilitation | _ | _ |
| G0308 | 180 D Implant Glucose Sensor | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 7/1/2022 | _ |
| G0309 | Rem/Inser Glu Sensor Dif Sit | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 7/1/2022 | _ |
| G0310 | Immunize counsel 5-15 min | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | #N/A | #N/A | | _ |
| G0311 | Immunize counsel 16-30 mins | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | #N/A | #N/A | | _ |
| G0312 | Immunize couns < 21yr 5-15 m | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | #N/A | #N/A | | _ |
| G0313 | Immunize couns < 21yr 6-30 m | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | #N/A | #N/A | | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| G0314 | Counsel immune <21 16-30 m | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | #N/A | #N/A | | _ |
| G0315 | Counsel immune <21 5-15 m | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | #N/A | #N/A | | _ |
| G0329 | Electromagnetic Therapy To One Or More Areas For Chronic Stage Iii And Stage Iv Pressure Ulcers Arterial Ulcers Diabetic Ulcers And Venous Stasis Ulcers Not Demonstrating Measurable Signs Of Healing After 30 Days Of Conventional Care As Part Of A Therapy Plan Of Care | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | THE803.008<br>MED201.027 | Electrostimulation and Electromagnetic Therapy for Treating Wounds<br>Non Covered Physical Therapy Services | _ | _ |
| G0333 | Pharmacy Dispensing Fee For Inhalation Drug(S); Initial 30-Day Supply As A Beneficiary | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.063 | Compounded Drug Products | _ | _ |
| G0339 | Image-Guided Robotic Linear Accelerator-Based Stereotactic Radiosurgery Complete Course Of Therapy In One Session Or First Session Of Fractionated Treatment | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| G0340 | Image-Guided Robotic Linear Accelerator-Based Stereotactic Radiosurgery Delivery Including Collimator Changes And Custom Plugging Fractionated Treatment All Lesions Per Session Second Through Fifth Sessions Maximum Five Sessions Per Course Of Treatment | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| G0341 | Percutaneous Islet Cell Transplant Includes Portal Vein Catheterization And Infusion | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR703.013 | Pancreas and Related Organ Tissue Transplantation | _ | _ |
| G0342 | Laparoscopy For Islet Cell Transplant Includes Portal Vein Catheterization And Infusion | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR703.013 | Pancreas and Related Organ Tissue Transplantation | _ | _ |
| G0343 | Laparotomy For Islet Cell Transplant Includes Portal Vein Catheterization And Infusion | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR703.013 | Pancreas and Related Organ Tissue Transplantation | _ | _ |
| G0372 | Physician Service Required To Establish And Document The Need For A Power Mobility Device (Use In Addition To Primary Evaluation And Management Code) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G0422 | Intensive Cardiac Rehabilitation; With Or Without Continuous Ecg Monitoring With Exercise Per Session | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE803.023 | Cardiac Rehabilitation (CR) | _ | _ |
| G0423 | Intensive Cardiac Rehabilitation; With Or Without Continuous Ecg Monitoring; Without Exercise Per Session | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE803.023 | Cardiac Rehabilitation (CR) | _ | _ |
| G0424 | Pulmonary Rehabilitation Including Exercise (Includes Monitoring) One Hour Per Session Up To Two Sessions Per Day | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE803.025 | Pulmonary Rehabilitation | _ | 12/31/2021 |
| G0428 | Collagen Meniscus Implant Procedure For Filling Meniscal Defects (E.G. Cmi Collagen Scaffold Menaflex) | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). May require Prior Authorization until 03/31/2022 per contract agreement. | SUR705.034 | Meniscal Allografts and Other Meniscal Implants | _ | _ |
| G0429 | Dermal Filler Injection(S) For The Treatment Of Facial Lipodystrophy Syndrome (Lds) (E.G. As A Result Of Highly Active Antiretroviral Therapy.) | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001 | Cosmetic and Reconstructive Procedures | _ | _ |
| G0448 | Insertion Or Replacement Of A Permanent Pacing Cardioverter-Defibrillator System With Transvenous Lead(S) Single Or Dual Chamber With Insertion Of Pacing Electrode Cardiac Venous System For Left Ventricular Pacing | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.003 | Implantable Cardioverter Defibrillators | _ | _ |
| G0455 | Preparation With Instillation Of Fecal Microbiota By Any Method Including Assessment Of Donor Specimen | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR703.049 | Fecal Microbiota Transplantation (FMT) | _ | _ |
| G0458 | Low Dose Rate (Ldr) Prostate Brachytherapy Services Composite Rate | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| G0460 | Autologous Platelet Rich Plasma For Chronic Wounds/Ulcers Including Phlebotomy Centrifugation And All Other Preparatory Procedures And Administration Per Treatment | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | RX501.034 | Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| G0465 | Autolog prp diab wound ulcer | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | RX501.034 | Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions | 4/1/2022 | _ |
| G0465 | Autolog prp diab wound ulcer | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.034 | Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions | 4/13/2021 | 3/31/2022 |
| G0516 | Insertion Of Non-Biodegradable Drug Delivery Implants 4 Or More (Services For Subdermal Rod Implant) | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.082<br>RX501.007<br>RX501.076 | Testosterone Replacement Therapies<br>Treatment of Opioid Dependence<br>Hormone Replacement Therapies (HRT) Using Implanted Pellets for Women and Delayed Puberty | _ | _ |
| G0517 | Removal Of Non-Biodegradable Drug Delivery Implants 4 Or More (Services For Subdermal Implants) | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.082<br>RX501.007<br>RX501.076 | Testosterone Replacement Therapies<br>Treatment of Opioid Dependence<br>Hormone Replacement Therapies (HRT) Using Implanted Pellets for Women and Delayed Puberty | _ | _ |
| G0518 | Removal With Reinsertion Non-Biodegradable Drug Delivery Implants 4 Or More (Services For Subdermal Implants) | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.007<br>RX501.076<br>RX501.082 | Hormone Replacement Therapies (HRT) Using Implanted Pellets for Women and Delayed Puberty<br>Testosterone Replacement Therapies<br>Treatment of Opioid Dependence | _ | _ |
| G2011 | Alcohol And/Or Substance (Other Than Tobacco) Misuse Structured Assessment (E.G. Audit Dast) And Brief Intervention 5-14 Minutes | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G2082 | Visit esketamine 56m or less | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.105 | Esketamine Nasal Spray | 8/1/2021 | _ |
| G2083 | Visit esketamine > 56m | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.105 | Esketamine Nasal Spray | 8/1/2021 | _ |
| G6001 | Ultrasonic Guidance For Placement Of Radiation Therapy Fields | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| G6002 | Stereoscopic X-Ray Guidance For Localization Of Target Volume For The Delivery Of Radiation Therapy | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| G6003 | Radiation Treatment Delivery Single Treatment Area Single Port Or Parallel Opposed Ports Simple Blocks Or No Blocks: Up To 5Mev | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| G6004 | Radiation Treatment Delivery Single Treatment Area Single Port Or Parallel Opposed Ports Simple Blocks Or No Blocks: 6-10Mev | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| G6005 | Radiation Treatment Delivery Single Treatment Area Single Port Or Parallel Opposed Ports Simple Blocks Or No Blocks: 11-19Mev | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| G6006 | Radiation Treatment Delivery Single Treatment Area Single Port Or Parallel Opposed Ports Simple Blocks Or No Blocks: 20Mev Or Greater | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| G6007 | Radiation Treatment Delivery 2 Separate Treatment Areas 3 Or More Ports On A Single Treatment Area Use Of Multiple Blocks: Up To 5Mev | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| G6008 | Radiation Treatment Delivery 2 Separate Treatment Areas 3 Or More Ports On A Single Treatment Area Use Of Multiple Blocks: 6-10Mev | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| G6009 | Radiation Treatment Delivery 2 Separate Treatment Areas 3 Or More Ports On A Single Treatment Area Use Of Multiple Blocks: 11-19Mev | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| G6010 | Radiation Treatment Delivery 2 Separate Treatment Areas 3 Or More Ports On A Single Treatment Area Use Of Multiple Blocks: 20 Mev Or Greater | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |

| | | | | | | |
|---|---|---|---|---|---|---|
| G6011 | Radiation Treatment Delivery 3 Or More Separate Treatment Areas Custom Blocking Tangential Ports Wedges Rotational Beam Compensators Electron Beam; Up To 5Mev | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| G6012 | Radiation Treatment Delivery 3 Or More Separate Treatment Areas Custom Blocking Tangential Ports Wedges Rotational Beam Compensators Electron Beam; 6-10Mev | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| G6013 | Radiation Treatment Delivery 3 Or More Separate Treatment Areas Custom Blocking Tangential Ports Wedges Rotational Beam Compensators Electron Beam; 11-19Mev | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| G6014 | Radiation Treatment Delivery 3 Or More Separate Treatment Areas Custom Blocking Tangential Ports Wedges Rotational Beam Compensators Electron Beam; 20Mev Or Greater | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| G6015 | Intensity Modulated Treatment Delivery Single Or Multiple Fields/Arcs Via Narrow Spatially And Temporally Modulated Beams Binary Dynamic Mlc Per Treatment Session | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| G6016 | Compensator-Based Beam Modulation Treatment Delivery Of Inverse Planned Treatment Using 3 Or More High Resolution (Milled Or Cast) Compensator Convergent Beam Modulated Fields Per Treatment Session | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| G8395 | Left Ventricular Ejection Fraction (Lvef) >= 40% Or Documentation As Normal Or | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G8396 | Left Ventricular Ejection Fraction (Lvef) Not Performed Or Documented | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G8397 | Dilated Macular Or Fundus Exam Performed Including Documentation Of The | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G8399 | Patient With Documented Results Of A Central Dual-Energy X-Ray Absorptiometry (Dxa) Ever Being Performed | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G8400 | Patient With Central Dual-Energy X-Ray Absorptiometry (Dxa) Results Not Documented Reason Not Given | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G8404 | Lower Extremity Neurological Exam Performed And Documented | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G8405 | Lower Extremity Neurological Exam Not Performed | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G8410 | Footwear Evaluation Performed And Documented | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G8415 | Footwear Evaluation Was Not Performed | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G8416 | Clinician Documented That Patient Was Not An Eligible Candidate For Footwear | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G8417 | Bmi Is Documented Above Normal Parameters And A Follow-Up Plan Is Documented | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G8418 | Bmi Is Documented Below Normal Parameters And A Follow-Up Plan Is Documented | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G8419 | Bmi Documented Outside Normal Parameters No Follow-Up Plan Documented No Reason Given | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G8420 | Bmi Is Documented Within Normal Parameters And No Follow-Up Plan Is Required | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G8421 | Bmi Not Documented And No Reason Is Given | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G8422 | Bmi Not Documented Documentation The Patient Is Not Eligible For Bmi Calculation | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | 12/31/2021 |
| G8427 | Eligible Clinician Attests To Documenting In The Medical Record They Obtained Updated Or Reviewed The Patient'S Current Medications | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G8428 | Current List Of Medications Not Documented As Obtained Updated Or Reviewed By The Eligible Clinician Reason Not Given | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G8430 | Eligible Clinician Attests To Documenting In The Medical Record The Patient Is Not Eligible For A Current List Of Medications Being Obtained Updated Or Reviewed By The Eligible Clinician | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G8431 | Screening For Depression Is Documented As Being Positive And A Follow-Up Plan Is Documented | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| G8432 | Depression Screening Not Documented Reason Not Given | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G8433 | Screening For Depression Not Completed Documented Reason | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G8450 | Beta-Blocker Therapy Prescribed | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G8451 | Beta-Blocker Therapy For Lvef < 40% Not Prescribed For Reasons Documented By The Clinician (E.G. Low Blood Pressure Fluid Overload Asthma Patients Recently Treated With An Intravenous Positive Inotropic Agent Allergy Intolerance Other Medical Reasons Patient Declined Other Patient Reasons Or Other Reasons Attributable To The Healthcare System) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G8452 | Beta-Blocker Therapy Not Prescribed | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G8465 | High Or Very High Risk Of Recurrence Of Prostate Cancer | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G8473 | Angiotensin Converting Enzyme (Ace) Inhibitor Or Angiotensin Receptor Blocker | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G8474 | Angiotensin Converting Enzyme (Ace) Inhibitor Or Angiotensin Receptor Blocker (Arb) Therapy Not Prescribed For Reasons Documented By The Clinician (Eg Allergy Intolerance Pregnancy Renal Failure Due To Ace Inhibitor Diseases Of The Aortic Or Mitral Valve Other Medical Reasons) Or (Eg Patient Declined Other Patient Reasons) Or (Eg Lack Of Drug Availability Other Reasons Attributable To The Health Care System) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G8475 | Angiotensin Converting Enzyme (Ace) Inhibitor Or Angiotensin Receptor Blocker (Arb) Therapy Not Prescribed Reason Not Given | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G8476 | Most Recent Blood Pressure Has A Systolic Measurement Of < 140 Mmhg And A Diastolic Measurement Of < 90 Mmhg | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G8477 | Most Recent Blood Pressure Has A Systolic Measurement Of >=140 Mmhg And/Or A Diastolic Measurement Of >=90 Mmhg | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G8478 | Blood Pressure Measurement Not Performed Or Documented Reason Not Given | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G8482 | Influenza Immunization Administered Or Previously Received | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G8483 | Influenza Immunization Was Not Administered For Reasons Documented By Clinician (E.G. Patient Allergy Or Other Medical Reasons Patient Declined Or Other Patient Reasons Vaccine Not Available Or Other System Reasons) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G8484 | Influenza Immunization Was Not Administered Reason Not Given | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9012 | Other Specified Case Management Service Not Elsewhere Classified | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| G9050 | Oncology; Primary Focus Of Visit; Work-Up Evaluation Or Staging At The Time Of Cancer Diagnosis Or Recurrence (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9051 | Oncology; Primary Focus Of Visit; Treatment Decision-Making After Disease Is Staged Or Restaged Discussion Of Treatment Options Supervising/Coordinating Active Cancer Directed Therapy Or Managing Consequences Of Cancer Directed Therapy (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9052 | Oncology; Primary Focus Of Visit; Surveillance For Disease Recurrence For Patient Who Has Completed Definitive Cancer-Directed Therapy And Currently Lacks Evidence Of Recurrent Disease; Cancer Directed Therapy Might Be Considered In The Future (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| G9053 | Oncology; Primary Focus Of Visit; Expectant Management Of Patient With Evidence Of Cancer For Whom No Cancer Directed Therapy Is Being Administered Or Arranged At Present; Cancer Directed Therapy Might Be Considered In The Future (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9054 | Oncology; Primary Focus Of Visit; Supervising Coordinating Or Managing Care Of Patient With Terminal Cancer Or For Whom Other Medical Illness Prevents Further Cancer Treatment; Includes Symptom Management End-Of-Life Care Planning Management Of Palliative Therapies (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9055 | Oncology; Primary Focus Of Visit; Other Unspecified Service Not Otherwise Listed (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9056 | Oncology; Practice Guidelines; Management Adheres To Guidelines (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9057 | Oncology; Practice Guidelines; Management Differs From Guidelines As A Result Of Patient Enrollment In An Institutional Review Board Approved Clinical Trial (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9058 | Oncology; Practice Guidelines; Management Differs From Guidelines Because The Treating Physician Disagrees With Guideline Recommendations (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9059 | Oncology; Practice Guidelines; Management Differs From Guidelines Because The Patient After Being Offered Treatment Consistent With Guidelines Has Opted For Alternative Treatment Or Management Including No Treatment (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9060 | Oncology; Practice Guidelines; Management Differs From Guidelines For Reason(S) Associated With Patient Comorbid Illness Or Performance Status Not Factored Into Guidelines (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9061 | Oncology; Practice Guidelines; Patient'S Condition Not Addressed By Available Guidelines (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9062 | Oncology; Practice Guidelines; Management Differs From Guidelines For Other Reason(S) Not Listed (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9063 | Oncology; Disease Status; Limited To Non-Small Cell Lung Cancer; Extent Of Disease Initially Established As Stage I (Prior To Neo-Adjuvant Therapy If Any) With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9064 | Oncology; Disease Status; Limited To Non-Small Cell Lung Cancer; Extent Of Disease Initially Established As Stage Ii (Prior To Neo-Adjuvant Therapy If Any) With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9065 | Oncology; Disease Status; Limited To Non-Small Cell Lung Cancer; Extent Of Disease Initially Established As Stage Iii A (Prior To Neo-Adjuvant Therapy If Any) With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| G9066 | Oncology; Disease Status; Limited To Non-Small Cell Lung Cancer; Stage Iii B-Iv At Diagnosis Metastatic Locally Recurrent Or Progressive (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9067 | Oncology; Disease Status; Limited To Non-Small Cell Lung Cancer; Extent Of Disease Unknown Staging In Progress Or Not Listed (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9068 | Oncology; Disease Status; Limited To Small Cell And Combined Small Cell/Non-Small Cell; Extent Of Disease Initially Established As Limited With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9069 | Oncology; Disease Status; Small Cell Lung Cancer Limited To Small Cell And Combined Small Cell/Non-Small Cell; Extensive Stage At Diagnosis Metastatic Locally Recurrent Or Progressive (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9070 | Oncology; Disease Status; Small Cell Lung Cancer Limited To Small Cell And Combined Small Cell/Non-Small; Extent Of Disease Unknown Staging In Progress Or Not Listed (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9071 | Oncology; Disease Status; Invasive Female Breast Cancer (Does Not Include Ductal Carcinoma In Situ); Adenocarcinoma As Predominant Cell Type; Stage I Or Stage Iia-Iib; Or T3 N1 M0; And Er And/Or Pr Positive; With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9072 | Oncology; Disease Status; Invasive Female Breast Cancer (Does Not Include Ductal Carcinoma In Situ); Adenocarcinoma As Predominant Cell Type; Stage I Or Stage Iia-Iib; Or T3 N1 M0; And Er And Pr Negative; With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9073 | Oncology; Disease Status; Invasive Female Breast Cancer (Does Not Include Ductal Carcinoma In Situ); Adenocarcinoma As Predominant Cell Type; Stage Iiia-Iiib; And Not T3 N1 M0; And Er And/Or Pr Positive; With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9074 | Oncology; Disease Status; Invasive Female Breast Cancer (Does Not Include Ductal Carcinoma In Situ); Adenocarcinoma As Predominant Cell Type; Stage Iiia-Iiib; And Not T3 N1 M0; And Er And Pr Negative; With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9075 | Oncology; Disease Status; Invasive Female Breast Cancer (Does Not Include Ductal Carcinoma In Situ); Adenocarcinoma As Predominant Cell Type; M1 At Diagnosis Metastatic Locally Recurrent Or Progressive (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9077 | Oncology; Disease Status; Prostate Cancer Limited To Adenocarcinoma As Predominant Cell Type; T1-T2C And Gleason 2-7 And Psa < Or Equal To 20 At Diagnosis With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| G9078 | Oncology; Disease Status; Prostate Cancer Limited To Adenocarcinoma As Predominant Cell Type; T2 Or T3A Gleason 8-10 Or Psa > 20 At Diagnosis With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9079 | Oncology; Disease Status; Prostate Cancer Limited To Adenocarcinoma As Predominant Cell Type; T3B-T4 Any N; Any T N1 At Diagnosis With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9080 | Oncology; Disease Status; Prostate Cancer Limited To Adenocarcinoma; After Initial Treatment With Rising Psa Or Failure Of Psa Decline (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9083 | Oncology; Disease Status; Prostate Cancer Limited To Adenocarcinoma; Extent Of Disease Unknown Staging In Progress Or Not Listed (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9084 | Oncology; Disease Status; Colon Cancer Limited To Invasive Cancer Adenocarcinoma As Predominant Cell Type; Extent Of Disease Initially Established As T1-3 N0 M0 With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9085 | Oncology; Disease Status; Colon Cancer Limited To Invasive Cancer Adenocarcinoma As Predominant Cell Type; Extent Of Disease Initially Established As T4 N0 M0 With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9086 | Oncology; Disease Status; Colon Cancer Limited To Invasive Cancer Adenocarcinoma As Predominant Cell Type; Extent Of Disease Initially Established As T1-4 N1-2 M0 With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9087 | Oncology; Disease Status; Colon Cancer Limited To Invasive Cancer Adenocarcinoma As Predominant Cell Type; M1 At Diagnosis Metastatic Locally Recurrent Or Progressive With Current Clinical Radiologic Or Biochemical Evidence Of Disease (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9088 | Oncology; Disease Status; Colon Cancer Limited To Invasive Cancer Adenocarcinoma As Predominant Cell Type; M1 At Diagnosis Metastatic Locally Recurrent Or Progressive Without Current Clinical Radiologic Or Biochemical Evidence Of Disease (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9089 | Oncology; Disease Status; Colon Cancer Limited To Invasive Cancer Adenocarcinoma As Predominant Cell Type; Extent Of Disease Unknown Staging In Progress Or Not Listed (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9090 | Oncology; Disease Status; Rectal Cancer Limited To Invasive Cancer Adenocarcinoma As Predominant Cell Type; Extent Of Disease Initially Established As T1-2 N0 M0 (Prior To Neo-Adjuvant Therapy If Any) With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| G9091 | Oncology; Disease Status; Rectal Cancer Limited To Invasive Cancer Adenocarcinoma As Predominant Cell Type; Extent Of Disease Initially Established As T3 N0 M0 (Prior To Neo-Adjuvant Therapy If Any) With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9092 | Oncology; Disease Status; Rectal Cancer Limited To Invasive Cancer Adenocarcinoma As Predominant Cell Type; Extent Of Disease Initially Established As T1-3 N1-2 M0 (Prior To Neo-Adjuvant Therapy If Any) With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9093 | Oncology; Disease Status; Rectal Cancer Limited To Invasive Cancer Adenocarcinoma As Predominant Cell Type; Extent Of Disease Initially Established As T4 Any N M0 (Prior To Neo-Adjuvant Therapy If Any) With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9094 | Oncology; Disease Status; Rectal Cancer Limited To Invasive Cancer Adenocarcinoma As Predominant Cell Type; M1 At Diagnosis Metastatic Locally Recurrent Or Progressive (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9095 | Oncology; Disease Status; Rectal Cancer Limited To Invasive Cancer Adenocarcinoma As Predominant Cell Type; Extent Of Disease Unknown Staging In Progress Or Not Listed (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9096 | Oncology; Disease Status; Esophageal Cancer Limited To Adenocarcinoma Or Squamous Cell Carcinoma As Predominant Cell Type; Extent Of Disease Initially Established As T1-T3 N0-N1 Or Nx (Prior To Neo-Adjuvant Therapy If Any) With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9097 | Oncology; Disease Status; Esophageal Cancer Limited To Adenocarcinoma Or Squamous Cell Carcinoma As Predominant Cell Type; Extent Of Disease Initially Established As T4 Any N M0 (Prior To Neo-Adjuvant Therapy If Any) With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9098 | Oncology; Disease Status; Esophageal Cancer Limited To Adenocarcinoma Or Squamous Cell Carcinoma As Predominant Cell Type; M1 At Diagnosis Metastatic Locally Recurrent Or Progressive (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9099 | Oncology; Disease Status; Esophageal Cancer Limited To Adenocarcinoma Or Squamous Cell Carcinoma As Predominant Cell Type; Extent Of Disease Unknown Staging In Progress Or Not Listed (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9100 | Oncology; Disease Status; Gastric Cancer Limited To Adenocarcinoma As Predominant Cell Type; Post R0 Resection (With Or Without Neoadjuvant Therapy) With No Evidence Of Disease Recurrence Progression Or Metastases (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| G9101 | Oncology; Disease Status; Gastric Cancer Limited To Adenocarcinoma As Predominant Cell Type; Post R1 Or R2 Resection (With Or Without Neoadjuvant Therapy) With No Evidence Of Disease Progression Or Metastases (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9102 | Oncology; Disease Status; Gastric Cancer Limited To Adenocarcinoma As Predominant Cell Type; Clinical Or Pathologic M0 Unresectable With No Evidence Of Disease Progression Or Metastases (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9103 | Oncology; Disease Status; Gastric Cancer Limited To Adenocarcinoma As Predominant Cell Type; Clinical Or Pathologic M1 At Diagnosis Metastatic Locally Recurrent Or Progressive (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9104 | Oncology; Disease Status; Gastric Cancer Limited To Adenocarcinoma As Predominant Cell Type; Extent Of Disease Unknown Staging In Progress Or Not Listed (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9105 | Oncology; Disease Status; Pancreatic Cancer Limited To Adenocarcinoma As Predominant Cell Type; Post R0 Resection Without Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9106 | Oncology; Disease Status; Pancreatic Cancer Limited To Adenocarcinoma; Post R1 Or R2 Resection With No Evidence Of Disease Progression Or Metastases (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9107 | Oncology; Disease Status; Pancreatic Cancer Limited To Adenocarcinoma; Unresectable At Diagnosis M1 At Diagnosis Metastatic Locally Recurrent Or Progressive (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9108 | Oncology; Disease Status; Pancreatic Cancer Limited To Adenocarcinoma; Extent Of Disease Unknown Staging In Progress Or Not Listed (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9109 | Oncology; Disease Status; Head And Neck Cancer Limited To Cancers Of Oral Cavity Pharynx And Larynx With Squamous Cell As Predominant Cell Type; Extent Of Disease Initially Established As T1-T2 And N0 M0 (Prior To Neo-Adjuvant Therapy If Any) With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9110 | Oncology; Disease Status; Head And Neck Cancer Limited To Cancers Of Oral Cavity Pharynx And Larynx With Squamous Cell As Predominant Cell Type; Extent Of Disease Initially Established As T3-4 And/Or N1-3 M0 (Prior To Neo-Adjuvant Therapy If Any) With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9111 | Oncology; Disease Status; Head And Neck Cancer Limited To Cancers Of Oral Cavity Pharynx And Larynx With Squamous Cell As Predominant Cell Type; M1 At Diagnosis Metastatic Locally Recurrent Or Progressive (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| G9112 | Oncology; Disease Status; Head And Neck Cancer Limited To Cancers Of Oral Cavity Pharynx And Larynx With Squamous Cell As Predominant Cell Type; Extent Of Disease Unknown Staging In Progress Or Not Listed (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9113 | Oncology; Disease Status; Ovarian Cancer Limited To Epithelial Cancer; Pathologic Stage Ia-B (Grade 1) Without Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9114 | Oncology; Disease Status; Ovarian Cancer Limited To Epithelial Cancer; Pathologic Stage Ia-B (Grade 2-3); Or Stage Ic (All Grades); Or Stage Ii; Without Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9115 | Oncology; Disease Status; Ovarian Cancer Limited To Epithelial Cancer; Pathologic Stage Iii-Iv; Without Evidence Of Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9116 | Oncology; Disease Status; Ovarian Cancer Limited To Epithelial Cancer; Evidence Of Disease Progression Or Recurrence And/Or Platinum Resistance (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9117 | Oncology; Disease Status; Ovarian Cancer Limited To Epithelial Cancer; Extent Of Disease Unknown Staging In Progress Or Not Listed (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9123 | Oncology; Disease Status; Chronic Myelogenous Leukemia Limited To Philadelphia Chromosome Positive And/Or Bcr-Abl Positive; Chronic Phase Not In Hematologic Cytogenetic Or Molecular Remission (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9124 | Oncology; Disease Status; Chronic Myelogenous Leukemia Limited To Philadelphia Chromosome Positive And/Or Bcr-Abl Positive; Accelerated Phase Not In Hematologic Cytogenetic Or Molecular Remission (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9125 | Oncology; Disease Status; Chronic Myelogenous Leukemia Limited To Philadelphia Chromosome Positive And/Or Bcr-Abl Positive; Blast Phase Not In Hematologic Cytogenetic Or Molecular Remission (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9126 | Oncology; Disease Status; Chronic Myelogenous Leukemia Limited To Philadelphia Chromosome Positive And/Or Bcr-Abl Positive; In Hematologic Cytogenetic Or Molecular Remission (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9128 | Oncology; Disease Status; Limited To Multiple Myeloma Systemic Disease; Smoldering Stage I (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9129 | Oncology; Disease Status; Limited To Multiple Myeloma Systemic Disease; Stage Ii Or Higher (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9130 | Oncology; Disease Status; Limited To Multiple Myeloma Systemic Disease; Extent Of Disease Unknown Staging In Progress Or Not Listed (For Use In A Medicare-Approved Demonstration Project) | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| G9140 | Frontier Extended Stay Clinic Demonstration; For A Patient Stay In A Clinic Approved For The Cms Demonstration Project; The Following Measures Should Be Present: The Stay Must Be Equal To Or Greater Than 4 Hours; Weather Or Other Conditions Must Prevent Transfer Or The Case Falls Into A Category Of Monitoring And Observation Cases That Are Permitted By The Rules Of The Demonstration; There Is A Maximum Frontier Extended Stay Clinic (Fesc) Visit Of 48 Hours Except In The Case When Weather Or Other Conditions Prevent Transfer; Payment Is Made On Each Period Up To 4 Hours After The First 4 Hours | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| G9143 | Warfarin Responsiveness Testing By Genetic Technique Using Any Method Any Number Of Specimen(S) | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list |
| G9147 | Outpatient Intravenous Insulin Treatment (Oivit) Either Pulsatile Or Continuous By Any Means Guided By The Results Of Measurements For:Respiratory Quotient; And/Or Urine Urea Nitrogen (Uun); And/Or Arterial Venous Or Capillary Glucose; And/Or Potassium Concentration | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED201.028 | Intermittent Intravenous Insulin Therapy | _ | _ |
| H0031 | Mental Health Assessment By Non-Physician | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| H0032 | Mental Health Service Plan Development By Non-Physician | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| H0038 | Self-Help/Peer Services Per 15 Minutes | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| H0039 | Assertive Community Treatment Face-To-Face Per 15 Minutes | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| H0040 | Assertive Community Treatment Program Per Diem | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| H0041 | Foster Care Child Non-Therapeutic Per Diem | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| H0042 | Foster Care Child Non-Therapeutic Per Month | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| H0043 | Supported Housing Per Diem | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| H0044 | Supported Housing Per Month | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| H0045 | Respite Care Services Not In The Home Per Diem | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| H0046 | Mental Health Services Not Otherwise Specified | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| H0047 | Alcohol And/Or Other Drug Abuse Services Not Otherwise Specified | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| H1010 | Non-Medical Family Planning Education Per Session | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| H1011 | Family Assessment By Licensed Behavioral Health Professional For State Defined Purposes | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| H2000 | Comprehensive Multidisciplinary Evaluation | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| H2011 | Crisis Intervention Service Per 15 Minutes | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| H2012 | Behavioral Health Day Treatment Per Hour | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| H2013 | Psychiatric Health Facility Service Per Diem | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| H2014 | Skills Training And Development Per 15 Minutes | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| H2015 | Comprehensive Community Support Services Per 15 Minutes | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| H2016 | Comprehensive Community Support Services Per Diem | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| H2021 | Community-Based Wrap-Around Services Per 15 Minutes | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| H2022 | Community-Based Wrap-Around Services Per Diem | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| H2023 | Supported Employment Per 15 Minutes | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| H2024 | Supported Employment Per Diem | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| H2025 | Ongoing Support To Maintain Employment Per 15 Minutes | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| H2026 | Ongoing Support To Maintain Employment Per Diem | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| H2027 | Psychoeducational Service Per 15 Minutes | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| H2028 | Sexual Offender Treatment Service Per 15 Minutes | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| H2029 | Sexual Offender Treatment Service Per Diem | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| H2030 | Mental Health Clubhouse Services Per 15 Minutes | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| H2031 | Mental Health Clubhouse Services Per Diem | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| H2032 | Activity Therapy Per 15 Minutes | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| H2033 | Multisystemic Therapy For Juveniles Per 15 Minutes | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| H2034 | Alcohol And/Or Drug Abuse Halfway House Services Per Diem | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| H2037 | Developmental Delay Prevention Activities Dependent Child Of Client Per 15 Minutes | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| J0129 | Injection Abatacept 10 Mg (Code May Be Used For Medicare When Drug Administered Under The Direct Supervision Of A Physician Not For Use When Drug Is Self Administered) | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.113<br>RX501.096 | Specialty Medication Administration Site of Care<br>Abatacept | | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.137 | Aducanumab-avwa | 1/1/2022 | |
| J0178 | Injection Aflibercept 1 Mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | OTH903.027<br>OTH903.015<br>OTH903.020 | Intravitreal Angiogenesis Inhibitors for Choroidal Vascular Conditions<br>Intravitreal Angiogenesis Inhibitors for Retinal Vascular Disorders<br>Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV) | | |
| J0180 | Injection Agalsidase Beta 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.096<br>RX501.067 | Specialty Medication Administration Site of Care<br>Enzyme-Replacement Therapy for Lysosomal Storage Disorders | | |
| J0202 | Injection Alemtuzumab 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.077 | Alemtuzumab | | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | N/A | N/A | | |
| J0219 | Inj Aval Alfa-Nqpt 4Mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.067 | Enzyme-Replacement Therapy for Lysosomal Storage Disorders | | |
| J0220 | Injection Alglucosidase Alfa 10 Mg Not Otherwise Specified | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.067 | Enzyme-Replacement Therapy for Lysosomal Storage Disorders | | |
| J0221 | Injection Alglucosidase Alfa (Lumizyme) 10 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.096<br>RX501.067 | Specialty Medication Administration Site of Care<br>Enzyme-Replacement Therapy for Lysosomal Storage Disorders | | |
| J0222 | Inj. Patisiran 0.1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.096<br>RX501.102 | Specialty Medication Administration Site of Care<br>Patisiran (Onpattro) | 7/1/2021 | |
| J0223 | Injection Givosiran 0.5 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.125<br>RX501.096 | Givosiran<br>Specialty Medication Administration Site of Care | | |
| J0224 | Inj. Lumasiran 0.5 Mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.133 | Lumasiran | 7/1/2021 | |
| J0256 | Injection Alpha 1 Proteinase Inhibitor (Human) Not Otherwise Specified 10 Mg | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | | | | |
| J0270 | Injection Alprostadil 1. 25 Mcg (Code May Be Used For Medicare When Drug Administered Under The Direct Supervision Of A Physician Not For Use When Drug Is Self Administered) | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.030 | Sexual Dysfunctions, Assessment and Treatment | | |
| J0275 | Alprostadil Urethral Suppository (Code May Be Used For Medicare When Drug Administered Under The Direct Supervision Of A Physician Not For Use When Drug Is Self Administered) | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.030 | Sexual Dysfunctions, Assessment and Treatment | | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE801.008 | Chelation Therapy | | |
| J0490 | Injection Belimumab 10 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.116<br>RX501.096 | Belimumab<br>Specialty Medication Administration Site of Care | 7/1/2021 | |
| J0491 | Inj Anifrolumab-Fnia 1Mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.138 | Anifrolumab-fnia | | |
| J0517 | Injection Benralizumab 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.100<br>RX501.096 | Benralizumab<br>Specialty Medication Administration Site of Care | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| J0565 | Injection Bezlotoxumab 10 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.093 | Bezlotoxumab (Zinplava) | _ | _ |
| J0567 | Injection Cerliponase Alfa 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.092 | Cerliponase alfa | _ | _ |
| J0584 | Injection Burosumab-Twza 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.058<br>RX501.096 | Burosumab-twza<br>Specialty Medication Administration Site of Care | _ | _ |
| J0585 | Injection Onabotulinumtoxina 1 Unit | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | MED201.014<br>RX501.019 | Botulinum Toxin Treatment of Hyperhidrosis | _ | _ |
| J0586 | Injection Abobotulinumtoxina 5 Units | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | MED201.014<br>RX501.019 | Botulinum Toxin Treatment of Hyperhidrosis | _ | _ |
| J0587 | Injection Rimabotulinumtoxinb 100 Units | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | MED201.014<br>RX501.019 | Botulinum Toxin Treatment of Hyperhidrosis | _ | _ |
| J0588 | Injection Incobotulinumtoxin A 1 Unit | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | MED201.014<br>RX501.019 | Botulinum Toxin Treatment of Hyperhidrosis | _ | _ |
| J0598 | Injection C-1 Esterase Inhibitor (Human) Cinryze 10 Units | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.096<br>RX504.013 | Specialty Medication Administration Site of Care Management of Hereditary Angioedema (HAE) with C1 Esterase Inhibitor, Human and Ecallantide | _ | _ |
| J0600 | Injection Edetate Calcium Disodium Up To 1000 Mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE801.008 | Chelation Therapy | _ | _ |
| J0638 | Injection Canakinumab 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.119<br>RX501.096 | Canakinumab<br>Specialty Medication Administration Site of Care | _ | _ |
| J0717 | Injection Certolizumab Pegol 1 Mg (Code May Be Used For Medicare When Drug Administered Under The Direct Supervision Of A Physician Not For Use When Drug Is Self Administered) | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.096<br>RX501.111 | Specialty Medication Administration Site of Care<br>Certolizumab Pegol | _ | _ |
| J0775 | Injection Collagenase Clostridium Histolyticum 0.01 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.073 | Clostridial Collagenase for Fibroproliferative Disorders | _ | _ |
| J0791 | Inj Crizanlizumab-Tmca 5Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.096 | Specialty Medication Administration Site of Care | 3/1/2021 | _ |
| J0881 | Injection Darbepoetin Alfa 1 Microgram (Non-Esrd Use) | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.069 | Erythropoiesis-Stimulating Agents (ESAs) | _ | _ |
| J0885 | Injection Epoetin Alfa (For Non-Esrd Use) 1000 Units | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.069 | Erythropoiesis-Stimulating Agents (ESAs) | _ | Moved to PA list |
| J0888 | Injectin Epoetin Beta 1 Microgram (For Non Esrd Use) | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.069 | Erythropoiesis-Stimulating Agents (ESAs) | _ | _ |
| J0895 | Injection Deferoxamine Mesylate 500 Mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE801.008 | Chelation Therapy | _ | _ |
| J0896 | Inj luspatercept-aamt 0.25mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | 8/1/2021 | Moved to PA list |
| J1071 | Injection Testosterone Cypionate 1Mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR717.001<br>RX501.076 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Testosterone Replacement Therapies | _ | _ |
| J1290 | Injection Ecallantide 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.096<br>RX504.013 | Specialty Medication Administration Site of Care Management of Hereditary Angioedema (HAE) with C1 Esterase Inhibitor, Human and Ecallantide | _ | _ |
| J1300 | Injection Eculizumab 10 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.066<br>RX501.096 | Specialty Medication Administration Site of Care<br>Eculizumab | _ | _ |
| J1301 | Injection Edaravone 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.095<br>RX501.096 | Specialty Medication Administration Site of Care<br>Edaravone | _ | _ |
| J1302 | Inj sutimlimab-jome 10 mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.087 | FDA-Approved Drugs and Biologicals | 10/1/2022 | |
| J1303 | Injection Ravulizumab-Cwvz 10 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.107<br>RX501.096 | Ravulizumab-cwvz (Ultomiris)<br>Specialty Medication Administration Site of Care | _ | _ |
| J1305 | Inj Evinacumab-Dgnb 5Mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.136 | Evinacumab-dgnb | 10/1/2021 | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| J1306 | Injection Inclisiran 1 Mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.142 | Inclisiran | 7/1/2022 | _ |
| J1322 | Injection Elosulfase Alfa 1Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.096<br>RX501.067 | Specialty Medication Administration Site of Care<br>Enzyme-Replacement Therapy for Lysosomal Storage Disorders | _ | _ |
| J1325 | Injection Epoprostenol 0. 5 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.056 | Advanced Therapies for Pharmacologic Treatment of Pulmonary Hypertension | _ | _ |
| J1426 | Injection Casimersen 10 Mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.135 | Casimersen | 10/1/2021 | _ |
| J1427 | Vitolarsen, 10 mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.129 | Vitolarsen | 5/1/2021 | _ |
| J1428 | Injection Eteplirsen 10 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.084 | Eteplirsen | _ | _ |
| J1429 | Injection Golodirsen 10 Mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.122 | Golodirsen | _ | _ |
| J1458 | Injection Galsulfase 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.096<br>RX501.067 | Specialty Medication Administration Site of Care<br>Enzyme-Replacement Therapy for Lysosomal Storage Disorders | _ | _ |
| J1459 | Injection Immune Globulin (Privigen) Intravenous Non-Lyophilized (E.G. Liquid) 500 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.096<br>RX504.003 | Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])<br>Specialty Medication Administration Site of Care | _ | Moved to PA list |
| J1551 | Inj Cutaquig 100 Mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX504.003 | Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) | 7/1/2022 | _ |
| J1554 | Injection, immune globulin (asceniv), 500mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX504.003 | Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) | 4/1/2021 | _ |
| J1555 | Injection Immune Globulin (Cuvitru) 100 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.096<br>RX504.003 | Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])<br>Specialty Medication Administration Site of Care | _ | Moved to PA list |
| J1556 | Injection Immune Globulin (Bivigam) 500 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.096<br>RX504.003 | Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])<br>Specialty Medication Administration Site of Care | _ | Moved to PA list |
| J1557 | Injection Immune Globulin (Gammaplex) Intravenous Non-Lyophilized (E.G. Liquid) 500 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.096<br>RX504.003 | Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])<br>Specialty Medication Administration Site of Care | _ | Moved to PA list |
| J1558 | Injection Immune Globulin (Xembify) 100 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX504.003<br>RX501.096 | Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])<br>Specialty Medication Administration Site of Care | _ | Moved to PA list |
| J1559 | Injection Immune Globulin (Hizentra) 100 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.096<br>RX504.003 | Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])<br>Specialty Medication Administration Site of Care | _ | Moved to PA list |
| J1561 | Injection Immune Globulin (Gamunex-C/Gammaked) Non-Lyophilized (E. G. Liquid) 500 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.096<br>RX504.003 | Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])<br>Specialty Medication Administration Site of Care | _ | Moved to PA list |
| J1562 | Injection Immune Globulin (Vivaglobin) 100 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX504.003 | Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) | _ | 11/30/2022 |

| | | | | | | |
|---|---|---|---|---|---|---|
| J1566 | Injection Immune Globulin Intravenous Lyophilized (E. G. Powder) Not Otherwise Specified 500 Mg | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. May require Prior Authorization based on contract agreement. | RX501.096<br>RX504.003 | Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])<br>Specialty Medication Administration Site of Care | _ | _ |
| J1568 | Injection Immune Globulin (Octagam) Intravenous Nonlyophilized (E.G. Liquid) 500 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.096<br>RX504.003 | Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])<br>Specialty Medication Administration Site of Care | _ | Moved to PA list |
| J1569 | Injection Immune Globulin (Gammagard Liquid) Non-Lyophilized (E. G. Liquid) 500 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.096<br>RX504.003 | Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])<br>Specialty Medication Administration Site of Care | _ | Moved to PA list |
| J1572 | Injection Immune Globulin (Flebogamma/Flebogamma Dif) Intravenous Non-Lyophilized (E.G. Liquid) 500 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.096<br>RX504.003 | Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])<br>Specialty Medication Administration Site of Care | _ | Moved to PA list |
| J1575 | Injection Immune Globulin/Hyaluronidase (Hyqvia) 100 Mg Immuneglobulin | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.096<br>RX504.003 | Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])<br>Specialty Medication Administration Site of Care | _ | Moved to PA list |
| J1599 | Injection Immune Globulin Intravenous Non-Lyophilized (E.G. Liquid) Not Otherwise Specified 500 Mg | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. May require Prior Authorization based on contract agreement. | RX504.003 | Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) | _ | _ |
| J1602 | Injection Golimumab 1 Mg For Intravenous Use | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.112<br>RX501.096 | Specialty Medication Administration Site of Care<br>Golimumab | _ | _ |
| J1620 | Injection Gonadorelin Hydrochloride Per 100 Mcg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.041 | Gonadotropin-Releasing Hormone (GnRH) Agonists and Antagonists | _ | _ |
| J1632 | Injection Brexanolone 1 Mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.106 | Brexanolone for Postpartum Depression | _ | _ |
| J1675 | Injection Histrelin Acetate 10 Micrograms | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.041 | Gonadotropin-Releasing Hormone (GnRH) Agonists and Antagonists | _ | _ |
| J1726 | Injection Hydroxyprogesterone Caproate (Makena) 10 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.062 | Progesterone Therapy as a Technique to Reduce Preterm Delivery in High-Risk Pregnancies | _ | _ |
| J1729 | Injection Hydroxyprogesterone Caproate Not Otherwise Specified 10 Mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.062 | Progesterone Therapy as a Technique to Reduce Preterm Delivery in High-Risk Pregnancies | _ | _ |
| J1743 | Injection Idursulfase 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.096<br>RX501.067 | Specialty Medication Administration Site of Care<br>Enzyme-Replacement Therapy for Lysosomal Storage Disorders | _ | _ |
| J1745 | Injection Infliximab Excludes Biosimilar 10 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.051<br>RX501.096<br>THE801.028 | Infliximab and Associated Biosimilars<br>Specialty Medication Administration Site of Care<br>Acne Management | _ | _ |
| J1746 | Injection Ibalizumab-Uiyk 10 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.099<br>RX501.096 | Ibalizumab-uiyk (Trogarzo)<br>Specialty Medication Administration Site of Care | _ | _ |
| J1786 | Injection Imiglucerase 10 Units | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.096<br>RX501.067 | Specialty Medication Administration Site of Care<br>Enzyme-Replacement Therapy for Lysosomal Storage Disorders | _ | _ |
| J1823 | Inj. Inebilizumab-Cdon 1 Mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.127 | Crizanlizumab-tmca | 3/1/2021 | _ |
| J1931 | Injection Laronidase 0.1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.096<br>RX501.067 | Specialty Medication Administration Site of Care<br>Enzyme-Replacement Therapy for Lysosomal Storage Disorders | _ | _ |
| J1932 | Inj lanreotide (cipla) 1mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | | _ | 10/1/2022 | |
| J1950 | Injection Leuprolide Acetate (For Depot Suspension) Per 3. 75 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.041 | Gonadotropin-Releasing Hormone (GnRH) Agonists and Antagonists | _ | Moved to PA list |

| | | | | | | |
|---|---|---|---|---|---|---|
| J1951 | Inj Fensolvi 0.25 Mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.041 | Gonadotropin-Releasing Hormone (GnRH) Agonists and Antagonists | 7/1/2021 | |
| J2182 | Injection Mepolizumab 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.096<br>RX501.080 | Mepolizumab<br>Specialty Medication Administration Site of Care | | |
| J2278 | Injection Ziconotide 1 Microgram | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.060 | Ziconotide | | |
| J2320 | Injection Nandrolone Decanoate Up To 50 Mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR717.001<br>RX501.076 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Testosterone Replacement Therapies | | |
| J2323 | Injection Natalizumab 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.096<br>RX501.059 | Specialty Medication Administration Site of Care<br>Tysabri (Natalizumab) | | 10/15/2022 |
| J2326 | Injection Nusinersen 0.1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.086 | Nusinersen (Spinraza) | | 10/15/2022 |
| J2350 | Injection Ocrelizumab 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.085<br>RX501.096 | Ocrelizumab<br>Specialty Medication Administration Site of Care | | |
| J2356 | Inj Tezepelumab-Ekko 1Mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.143 | Tezepelumab-ekko | 7/1/2022 | |
| J2357 | Injection Omalizumab 5 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.058<br>RX501.096 | Specialty Medication Administration Site of Care<br>Omalizumab | | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.030 | Sexual Dysfunctions, Assessment and Treatment | | |
| J2502 | Injection Pasireotide Long Acting 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.079 | Signifor LAR (pasireotide) | | |
| J2503 | Injection Pegaptanib Sodium 0.3 Mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | OTH903.027<br>OTH903.015<br>OTH903.020 | Intravitreal Angiogenesis Inhibitors for Choroidal Vascular Conditions<br>Intravitreal Angiogenesis Inhibitors for Retinal Vascular Disorders<br>Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV) | | |
| J2507 | Injection Pegloticase 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.096<br>RX501.120 | Specialty Medication Administration Site of Care<br>Pegloticase | | |
| J2562 | Injection Plerixafor 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | | Moved to PA list |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | OTH903.044 | Faricimab-svoa | 10/1/2022 | |
| J2778 | Injection Ranibizumab 0.1 Mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | OTH903.027<br>OTH903.015<br>OTH903.041 | Intravitreal Angiogenesis Inhibitors for Retinal Vascular Disorders<br>Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV)<br>Ranibizumab Injections, Implants and Biosimilars | | |
| J2779 | Inj Susvimo 0.1 Mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | OTH903.041 | Ranibizumab Injections, Implants and Biosimilars | 7/1/2022 | |
| J2786 | Injection Reslizumab 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.096<br>RX501.083 | Reslizumab<br>Specialty Medication Administration Site of Care | | |
| J2787 | Riboflavin 5'-Phosphate Ophthalmic Solution Up To 3 Ml | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | OTH903.028 | Corneal Collagen Cross-Linking | | |
| J2840 | Injection Sebelipase Alfa 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.096<br>RX501.067 | Specialty Medication Administration Site of Care<br>Enzyme-Replacement Therapy for Lysosomal Storage Disorders | | |
| J2860 | Injection Siltuximab 10 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | | Moved to PA list |
| J3032 | Injection Eptinezumab-Jjmr 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.124<br>RX501.096 | Eptinezumab-jjmr<br>Specialty Medication Administration Site of Care | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| J3060 | Injection Taliglucerace Alfa 10 Units | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.067<br>RX501.096 | Enzyme-Replacement Therapy for Lysosomal Storage Disorders<br>Specialty Medication Administration Site of Care | _ | _ |
| J3121 | Injection Testosterone Enanthate 1Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR717.001<br>RX501.076 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Testosterone Replacement Therapies | _ | _ |
| J3145 | Injection Testosterone Undecanoate 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR717.001<br>RX501.076 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Testosterone Replacement Therapies | _ | _ |
| J3241 | Injection Teprotumumab-Trbw 10 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.096<br>RX501.110 | Specialty Medication Administration Site of Care<br>Teprotumumab | _ | _ |
| J3245 | Injection Tildrakizumab 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.096<br>RX501.123 | Specialty Medication Administration Site of Care<br>Tildrakizumab-asmn | _ | _ |
| J3262 | Injection Tocilizumab 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.115<br>RX501.096 | Tocilizumab<br>Specialty Medication Administration Site of Care | _ | _ |
| J3285 | Injection Treprostinil 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.056 | Advanced Therapies for Pharmacologic Treatment of Pulmonary Hypertension | _ | _ |
| J3299 | Inj Xipere 1 Mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | 7/1/2022 | _ |
| J3315 | Injection Triptorelin Pamoate 3. 75 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | _ | Moved to PA list |
| J3316 | Injection Triptorelin Extended-Release 3.75 Mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.041<br>RX501.040 | Gonadotropin-Releasing Hormone (GnRH) Agonists and Antagonists<br>Human Growth Hormone (GH) | _ | _ |
| J3355 | Injection Urofollitropin 75 Iu | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| J3358 | Ustekinumab For Intravenous Injection 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.114<br>RX501.096 | Specialty Medication Administration Site of Care<br>Ustekinumab | _ | _ |
| J3380 | Injection Vedolizumab 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.117<br>RX501.096 | Specialty Medication Administration Site of Care<br>Vedolizumab | _ | _ |
| J3385 | Injection Velaglucerase Alfa 100 Units | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.096<br>RX501.067 | Specialty Medication Administration Site of Care<br>Enzyme-Replacement Therapy for Lysosomal Storage Disorders | _ | _ |
| J3396 | Injection Verteporfin 0.1 Mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | OTH903.015 | Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV) | _ | _ |
| J3397 | Injection Vestronidase Alfa-Vjbk 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.067 | Enzyme-Replacement Therapy for Lysosomal Storage Disorders | _ | _ |
| J3398 | Injection Voretigene Neparvovec-Rzyl 1 Billion Vector Genomes | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.098 | Gene Therapy for Inherited Retinal Dystrophy | _ | _ |
| J3399 | Injection Onasemnogene Abeparvovec-Xioi Per Treatment Up To 5X10^15 Vector Genomes | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.104 | Zolgensma (onasemnogene abeparvovec-xioi) | _ | _ |
| J3490 | Unclassified Drugs | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. May require Prior Authorization based on 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE801.008 | Chelation Therapy | _ | _ |
| J3570 | Laetrile Amygdalin Vitamin B17 | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| J3590 | Unclassified Biologics | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. May require Prior Authorization based on contract agreement. | _ | _ | _ | _ |
| J3591 | Unclassified Drug Or Biological Used For Esrd On Dialysis | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| J7177 | Injection Human Fibrinogen Concentrate (Fibryga) 1 Mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.072 | Human Fibrinogen Concentrate (RiaSTAP and Fibryga) | _ | _ |
| J7178 | Injection Human Fibrinogen Concentrate Not Otherwise Specified 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.072<br>RX501.075 | Hemophilia Agents<br>Human Fibrinogen Concentrate (RiaSTAP and Fibryga) | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| J7192 | Factor Viii (Antihemophilic Factor Recombinant) Per I.U. Not Otherwise Specified | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| J7195 | Injection Factor Ix (Antihemophilic Factor Recombinant) Per Iu Not Otherwise Specified | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| J7199 | Hemophilia Clotting Factor Not Otherwise Classified | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| J7308 | Aminolevulinic Acid Hcl For Topical Administration 20% Single Unit Dosage Form (354 Mg) | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE801.027<br>THE801.028 | Dermatologic Applications of Photodynamic Therapy (PDT)<br>Acne Management | _ | _ |
| J7309 | Methyl Aminolevulinate (Mal) For Topical Administration 16.8% 1 Gram | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE801.027 | Dermatologic Applications of Photodynamic Therapy (PDT) | _ | _ |
| J7311 | Injection Fluocinolone Acetonide Intravitreal Implant (Retisert) 0.01 Mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | OTH903.024 | Intravitreal, Punctum and Intracameral Implants | _ | _ |
| J7312 | Injection Dexamethasone Intravitreal Implant 0.1 Mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | OTH903.024 | Intravitreal, Punctum and Intracameral Implants | _ | _ |
| J7313 | Injection Fluocinolone Acetonide Intravitreal Implant (Iluvien) 0.01 Mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | OTH903.024 | Intravitreal, Punctum and Intracameral Implants | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | OTH903.026 | Ocriplasmin for Symptomatic Vitreomacular Adhesion | _ | _ |
| J7330 | Autologous Cultured Chondrocytes Implant | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.035 | Autologous Chondrocyte Implantation (ACI) for Focal Articular Cartilage Lesions | _ | Moved to PA list |
| J7340 | Carbidopa 5 Mg/Levodopa 20 Mg Enteral Suspension 100 Ml | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX504.015 | Levodopa-Carbidopa Enteral Suspension (e.g. Duopa) for The Treatment of Parkinson Disease. | _ | _ |
| J7345 | Aminolevulinic Acid Hcl For Topical Administration 10% Gel 10 Mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE801.027 | Dermatologic Applications of Photodynamic Therapy (PDT) | _ | _ |
| J7351 | Injection Bimatoprost Intracameral Implant 1 Microgram | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | OTH903.024 | Intravitreal, Punctum and Intracameral Implants | _ | _ |
| J7402 | Mometasone Sinus Sinuva | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR706.001 | Nasal and Sinus Surgery | 5/15/2021 | _ |
| J7599 | Immunosuppressive Drug Not Otherwise Classified | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| J7604 | Acetylcysteine Inhalation Solution Compounded Product Administered Through | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | RX501.063 | Compounded Drug Products | _ | _ |
| J7607 | Levalbuterol Inhalation Solution Compounded Product Administered Through Dme Concentrated Form 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). | RX501.063 | Compounded Drug Products | _ | _ |
| J7609 | Albuterol Inhalation Solution Compounded Product Administered Through Dme Unit Dose 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). | RX501.063 | Compounded Drug Products | _ | _ |
| J7610 | Albuterol Inhalation Solution Compounded Product Administered Through Dme Concentrated Form 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). | RX501.063 | Compounded Drug Products | _ | _ |
| J7615 | Levalbuterol Inhalation Solution Compounded Product Administered Through Dme Unit Dose 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). | RX501.063 | Compounded Drug Products | _ | _ |
| J7622 | Beclomethasone Inhalation Solution Compounded Product Administered Through Dme Unit Dose Form Per Milligram | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | RX501.063 | Compounded Drug Products | _ | _ |
| J7624 | Betamethasone Inhalation Solution Compounded Product Administered Through Dme Unit Dose Form Per Milligram | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | RX501.063 | Compounded Drug Products | _ | _ |
| J7627 | Budesonide Inhalation Solution Compounded Product Administered Through Dme Unit Dose Form Up To 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). | RX501.063 | Compounded Drug Products | _ | _ |
| J7628 | Bitolterol Mesylate Inhalation Solution Compounded Product Administered Through Dme Concentrated Form Per Milligram | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | RX501.063 | Compounded Drug Products | _ | _ |
| J7629 | Bitolterol Mesylate Inhalation Solution Compounded Product Administered Through Dme Unit Dose Form Per Milligram | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | RX501.063 | Compounded Drug Products | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| J7632 | Cromolyn Sodium Inhalation Solution Compounded Product Administered Through | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | RX501.063 | Compounded Drug Products | _ | _ |
| J7634 | Budesonide Inhalation Solution Compounded Product Administered Through Dme Concentrated Form Per 0.25 Milligram | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | RX501.063 | Compounded Drug Products | _ | _ |
| J7635 | Atropine Inhalation Solution Compounded Product Administered Through Dme Concentrated Form Per Milligram | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | RX501.063 | Compounded Drug Products | _ | _ |
| J7636 | Atropine Inhalation Solution Compounded Product Administered Through Dme Unit Dose Form Per Milligram | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | RX501.063 | Compounded Drug Products | _ | _ |
| J7637 | Dexamethasone Inhalation Solution Compounded Product Administered Through Dme Concentrated Form Per Milligram | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | RX501.063 | Compounded Drug Products | _ | _ |
| J7638 | Dexamethasone Inhalation Solution Compounded Product Administered Through Dme Unit Dose Form Per Milligram | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | RX501.063 | Compounded Drug Products | _ | _ |
| J7640 | Formoterol Inhalation Solution Compounded Product Administered Through Dme Unit Dose Form 12 Micrograms | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | RX501.063 | Compounded Drug Products | _ | _ |
| J7641 | Flunisolide Inhalation Solution Compounded Product Administered Through Dme Unit Dose Per Milligram | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | RX501.063 | Compounded Drug Products | _ | _ |
| J7642 | Glycopyrrolate Inhalation Solution Compounded Product Administered Through Dme Concentrated Form Per Milligram | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | RX501.063 | Compounded Drug Products | _ | _ |
| J7643 | Glycopyrrolate Inhalation Solution Compounded Product Administered Through Dme Unit Dose Form Per Milligram | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | RX501.063 | Compounded Drug Products | _ | _ |
| J7645 | Ipratropium Bromide Inhalation Solution Compounded Product Administered Through Dme Unit Dose Form Per Milligram | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | RX501.063 | Compounded Drug Products | _ | _ |
| J7647 | Isoetharine Hcl Inhalation Solution Compounded Product Administered Through Dme Concentrated Form Per Milligram | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | RX501.063 | Compounded Drug Products | _ | _ |
| J7650 | Isoetharine Hcl Inhalation Solution Compounded Product Administered Through Dme Unit Dose Form Per Milligram | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | RX501.063 | Compounded Drug Products | _ | _ |
| J7657 | Isoproterenol Hcl Inhalation Solution Compounded Product Administered Through Dme Concentrated Form Per Milligram | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | RX501.063 | Compounded Drug Products | _ | _ |
| J7660 | Isoproterenol Hcl Inhalation Solution Compounded Product Administered Through Dme Unit Dose Form Per Milligram | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | RX501.063 | Compounded Drug Products | _ | _ |
| J7667 | Metaproterenol Sulfate Inhalation Solution Compounded Product Concentrated Form Per 10 Milligrams | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | RX501.063 | Compounded Drug Products | _ | _ |
| J7670 | Metaproterenol Sulfate Inhalation Solution Compounded Product Administered Through Dme Unit Dose Form Per 10 Milligrams | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | RX501.063 | Compounded Drug Products | _ | _ |
| J7676 | Pentamidine Isethionate Inhalation Solution Compounded Product Administered | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | RX501.063 | Compounded Drug Products | _ | _ |
| J7680 | Terbutaline Sulfate Inhalation Solution Compounded Product Administered Through Dme Concentrated Form Per Milligram | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | RX501.063 | Compounded Drug Products | _ | _ |
| J7681 | Terbutaline Sulfate Inhalation Solution Compounded Product Administered Through Dme Unit Dose Form Per Milligram | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | RX501.063 | Compounded Drug Products | _ | _ |
| J7683 | Triamcinolone Inhalation Solution Compounded Product Administered Through Dme Concentrated Form Per Milligram | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | RX501.063 | Compounded Drug Products | _ | _ |
| J7684 | Triamcinolone Inhalation Solution Compounded Product Administered Through Dme Unit Dose Form Per Milligram | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | RX501.063 | Compounded Drug Products | _ | _ |
| J7685 | Tobramycin Inhalation Solution Compounded Product Administered Through Dme Unit Dose Form Per 300 Milligrams | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | RX501.063 | Compounded Drug Products | _ | _ |
| J7699 | Noc Drugs Inhalation Solution Administered Through Dme | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| J7799 | Noc Drugs Other Than Inhalation Drugs Administered Through Dme | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ | |
| J7999 | Compounded Drug Not Otherwise Classified | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ | |
| J8498 | Antiemetic Drug Rectal/Suppository Not Otherwise Specified | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ | |
| J8499 | Prescription Drug Oral Non Chemotherapeutic Nos | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ | |
| J8597 | Antiemetic Drug Oral Not Otherwise Specified | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ | |
| J8999 | Prescription Drug Oral Chemotherapeutic Nos | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ | |
| J9020 | Injection Asparaginase Not Otherwise Specified 10 000 Units | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ | |
| J9022 | Injection Atezolizumab 10 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | _ | | Moved to PA list |
| J9023 | Injection Avelumab 10 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | _ | | Moved to PA list |
| J9032 | Injection Belinostat 10 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | _ | | Moved to PA list |
| J9035 | Injection Bevacizumab 10 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | OTH903.027 OTH903.015 OTH903.020 | Intravitreal Angiogenesis Inhibitors for Choroidal Vascular Conditions Intravitreal Angiogenesis Inhibitors for Retinal Vascular Disorders Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV) | _ | | Moved to PA list |
| J9037 | Injection, belantamab mafodontin-blmg, 0.5mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | | 4/1/2021 | Moved to PA list |
| J9039 | Injection Blinatumomab 1 Microgram | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | _ | | Moved to PA list |
| J9043 | Injection Cabazitaxel 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | _ | | Moved to PA list |
| J9044 | Injection Bortezomib Not Otherwise Specified 0.1 Mg | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ | |
| J9047 | Injection Carfilzomib 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | _ | | Moved to PA list |
| J9057 | Injection Copanlisib 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | _ | | Moved to PA list |
| J9119 | Injection Cemiplimab-Rwlc 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | _ | | Moved to PA list |
| J9144 | Daratumumab Hyaluronidase | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | | 2/1/2021 | Moved to PA list |
| J9145 | Injection Daratumumab 10 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | _ | | Moved to PA list |
| J9153 | Injection Liposomal 1 Mg Daunorubicin And 2.27 Mg Cytarabine | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | _ | | Moved to PA list |
| J9155 | Injection Degarelix 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | _ | | Moved to PA list |
| J9173 | Injection Durvalumab 10 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | _ | | Moved to PA list |
| J9176 | Injection Elotuzumab 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | _ | | Moved to PA list |
| J9177 | Injection Enfortumab Vedotin-Ejfv 0.25 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | _ | | Moved to PA list |
| J9202 | Goserelin Acetate Implant Per 3. 6 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.041 | Gonadotropin-Releasing Hormone (GnRH) Agonists and Antagonists | _ | | Moved to PA list |
| J9203 | Injection Gemtuzumab Ozogamicin 0.1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | _ | | Moved to PA list |
| J9204 | Injection Mogamulizumab-Kpkc 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | _ | | Moved to PA list |
| J9205 | Injection Irinotecan Liposome 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | _ | | Moved to PA list |
| J9217 | Leuprolide Acetate (For Depot Suspension) 7. 5 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.041 | Gonadotropin-Releasing Hormone (GnRH) Agonists and Antagonists | _ | | Moved to PA list |
| J9218 | Leuprolide Acetate Per 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.041 | Gonadotropin-Releasing Hormone (GnRH) Agonists and Antagonists | _ | | Moved to PA list |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| J9219 | Leuprolide Acetate Implant 65 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.041 | Gonadotropin-Releasing Hormone (GnRH) Agonists and Antagonists | _ | | Moved to PA list |
| J9223 | Inj. Lurbinectedin 0.1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | | 2/1/2021 | Moved to PA list |
| J9225 | Histrelin Implant (Vantas) 50 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | _ | | Moved to PA list |
| J9226 | Histrelin Implant (Supprelin La) 50 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.041 | Gonadotropin-Releasing Hormone (GnRH) Agonists and Antagonists | _ | | Moved to PA list |
| J9227 | Injection Isatuximab-Irfc 10 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | _ | | Moved to PA list |
| J9228 | Injection Ipilimumab 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | _ | | Moved to PA list |
| J9229 | Injection Inotuzumab Ozogamicin 0.1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | _ | | Moved to PA list |
| J9247 | Inj melphalan flufenami 1mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | N/A | N/A | | 10/1/2021 | _ |
| J9264 | Injection Paclitaxel Protein-Bound Particles 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | _ | | Moved to PA list |
| J9269 | Injection Tagraxofusp-Erzs 10 Micrograms | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | _ | | Moved to PA list |
| J9271 | Injection Pembrolizumab 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | _ | | Moved to PA list |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX502.061 | Oncology Medications | | 10/1/2022 | |
| J9281 | Mitomycin Instillation | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | | 2/1/2021 | Moved to PA list |
| J9285 | Injection Olaratumab 10 Mg | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | | 5/15/2021 | _ |
| J9295 | Injection Necitumumab 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | _ | | Moved to PA list |
| J9298 | Inj nivol relatlimab 3mg/1mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | N/A | N/A | | 10/1/2022 | 12/31/2022 |
| J9299 | Injection Nivolumab 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | _ | | Moved to PA list |
| J9301 | Injection Obinutuzumab 10 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | _ | | Moved to PA list |
| J9306 | Injection Pertuzumab 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | _ | | Moved to PA list |
| J9308 | Injection Ramucirumab 5 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | _ | | Moved to PA list |
| J9309 | Injection Polatuzumab Vedotin-Piiq 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | _ | | Moved to PA list |
| J9311 | Injection Rituximab 10 Mg And Hyaluronidase | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | _ | | Moved to PA list |
| J9312 | Injection Rituximab 10 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.030 | Rituximab and Biosimilars for Non-Oncologic Indications | _ | | Moved to PA list |
| J9313 | Injection Moxetumomab Pasudotox-Tdfk 0.01 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | _ | | Moved to PA list |
| J9316 | Injection, pertuzumab, trastuzumab, and hyaluronidase-zzxf, per 10 mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | | 5/1/2021 | Moved to PA list |
| J9317 | Sacituzumab Govitecan-Hziy | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | | 2/1/2021 | Moved to PA list |
| J9325 | Injection Talimogene Laherparepvec Per 1 Million Plaque Forming Units | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | _ | | Moved to PA list |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | | 7/1/2022 | _ |
| J9332 | Inj Efgartigimod 2Mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.141 | Efgartigimod alfa-fcab | | 7/1/2022 | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| J9349 | Injection, tafasitamab-cxix, 2mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | 4/1/2021 | Moved to PA list |
| J9352 | Injection Trabectedin 0.1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | _ | Moved to PA list |
| J9354 | Injection Ado-Trastuzumab Emtansine 1 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | _ | Moved to PA list |
| J9358 | Inj Fam-Trastu Deru-Nxki 1Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | 2/1/2021 | Moved to PA list |
| J9600 | Injection Porfimer Sodium 75 Mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE801.029 | Oncologic Applications of Photodynamic Therapy, Including Barrett Esophagus | _ | _ |
| J9999 | Not Otherwise Classified Antineoplastic Drugs | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. May require Prior Authorization based on contract agreement. | _ | _ | _ | _ |
| K0002 | Stnd hemi (low seat) whlchr | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0003 | Lightweight wheelchair | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0004 | High strength ltwt whlchr | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0005 | Ultralightweight wheelchair | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0006 | Heavy duty wheelchair | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0007 | Extra heavy duty wheelchair | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0008 | Cstm manual wheelchair/base | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0009 | Other manual wheelchair/base | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0010 | Stnd wt frame power whlchr | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0011 | Stnd wt pwr whlchr w control | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0012 | Ltwt portbl power whlchr | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0013 | Custom power whlchr base | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0014 | Other power whlchr base | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0053 | Elevate footrest articulate | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0056 | Seat ht <17 or >=21 ltwt wc | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0065 | Spoke protectors | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0455 | Pump uninterrupted infusion | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.056 | Advanced Therapies for Pharmacologic Treatment of Pulmonary Hypertension | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| K0669 | Seat/back cus no dmepdac ver | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0743 | Suction Pump, Home Model, Portable, For Use On Wounds | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.036 | Negative Pressure Wound Therapy (NPWT) for the Treatment of Wounds | _ | _ |
| K0744 | Absorptive Wound Dressing For Use With Suction Pump, Home Model, Portable, Pad Size 16 Square Inches Or Less | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.036 | Negative Pressure Wound Therapy (NPWT) for the Treatment of Wounds | _ | _ |
| K0745 | Absorptive Wound Dressing For Use With Suction Pump, Home Model, Portable, Pad Size More Than 16 Square Inches But Less Than Or Equal To 48 Square Inches | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.036 | Negative Pressure Wound Therapy (NPWT) for the Treatment of Wounds | _ | _ |
| K0746 | Absorptive Wound Dressing For Use With Suction Pump, Home Model, Portable, Pad Size Greater Than 48 Square Inches | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.036 | Negative Pressure Wound Therapy (NPWT) for the Treatment of Wounds | _ | _ |
| K0800 | POV group 1 std up to 300lbs | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0801 | POV group 1 hd 301-450 lbs | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0802 | POV group 1 vhd 451-600 lbs | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0806 | POV group 2 std up to 300lbs | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0808 | POV group 2 vhd 451-600 lbs | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0812 | Power operated vehicle NOC | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0814 | PWC gp 1 std port cap chair | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0815 | PWC gp 1 std seat/back | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0816 | PWC gp 1 std cap chair | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0821 | PWC gp 2 std port cap chair | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0823 | PWC gp 2 std cap chair | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0824 | PWC gp 2 hd seat/back | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0825 | PWC gp 2 hd cap chair | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| K0826 | PWC gp 2 vhd seat/back | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0827 | PWC gp vhd cap chair | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0828 | PWC gp 2 xtra hd seat/back | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0831 | PWC gp2 std seat elevate cap | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0837 | PWC gp 2 hd sing pow opt s/b | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0838 | PWC gp 2 hd sing pow opt cap | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0840 | PWC gp2 xhd sing pow opt s/b | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0848 | PWC gp 3 std seat/back | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0851 | PWC gp 3 hd cap chair | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0854 | PWC gp 3 xhd seat/back | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| K0855 | PWC gp 3 xhd cap chair | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0856 | PWC gp3 std sing pow opt s/b | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0858 | PWC gp3 hd sing pow opt s/b | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0859 | PWC gp3 hd sing pow opt cap | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0861 | PWC gp3 std mult pow opt s/b | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0862 | PWC gp3 hd mult pow opt s/b | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0863 | PWC gp3 vhd mult pow opt s/b | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0868 | PWC gp 4 std seat/back | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0871 | PWC gp 4 vhd seat/back | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0877 | PWC gp4 std sing pow opt s/b | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0878 | PWC gp4 std sing pow opt cap | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0880 | PWC gp4 vhd sing pow opt s/b | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0886 | PWC gp4 hd mult pow s/b | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K0890 | PWC gp5 ped sing pow opt s/b | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.010 | Wheelchairs and Accessories | _ | _ |
| K1002 | Ces system w/supplies access | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR702.019 | Cranial Electrotherapy Stimulation and Auricular Electrostimulation | _ | _ |
| 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). | THE803.008 | Non Covered Physical Therapy Services | _ | _ |
| 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). | DME103.008 | Powered Exoskeleton for Ambulation in Patients With Lower-Limb Disabilities | 3/1/2021 | _ |
| K1009 | Speech volume modulation sys | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | THE803.014 | Speech-Language Therapy (SLT) | 3/1/2021 | _ |
| K1013 | Enema tube, any, replac only | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | 4/1/2021 | _ |
| K1018 | Ext Up Limb Tremor Stim Wris | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | CPCP028 | Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU) | 8/15/2021 | _ |
| K1019 | Monthly Supp Use With K1018 | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | CPCP028 | Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU) | 8/15/2021 | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR712.021 | Vagus Nerve Stimulation (VNS) | 7/1/2021 | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | N/A | N/A | 10/1/2021 | _ |
| K1022 | Endoskel Posit Rotat Unit | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | 10/1/2021 | _ |
| 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). | MED201.040 | Transcutaneous Electrical Stimulation (TENS) and Transcutaneous Electrical Modulation Pain Reprocessing (TEMPR) | 1/1/2022 | _ |
| K1023 | Trans elec nerv periph nerv | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.040 | Transcutaneous Electrical Stimulation (TENS) and Transcutaneous Electrical Modulation Pain Reprocessing (TEMPR) | 10/1/2021 | 12/31/2021 |
| 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). | ADM1001.032 | Experimental, Investigational and/or Unproven Procedures/Services | 1/1/2022 | _ |
| K1024 | Non pneum comp control cal | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | ADM1001.032 | Experimental, Investigational and/or Unproven Procedures/Services | 10/1/2021 | 12/31/2021 |
| K1025 | Non pneum compress full arm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | ADM1001.032 | Experimental, Investigational and/or Unproven Procedures/Services | 1/1/2022 | _ |
| K1025 | Non pneum compress full arm | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | ADM1001.032 | Experimental, Investigational and/or Unproven Procedures/Services | 10/1/2021 | 12/31/2021 |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED204.005 | Diagnosis and Medical Management of Sleep Related Breathing Disorders | 10/1/2021 | _ |
| K1028 | Control Unit Neuromuscul Osa | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | | |
| K1029 | Oral Dv/App Neuromus Mouthpi | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | | |
| K1030 | Ext Recharge Bat Replacement | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED202.068 | Cardiac Contractility Modulation (CCM) Device | | |
| 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). | ADM1001.032 | Experimental, Investigational and/or Unproven Procedures/Services | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| K1031 | Non Pneu Comp Control W/O Ca | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | ADM1001.032 | Experimental, Investigational and/or Unproven Procedures/Services | | |
| 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). | ADM1001.032 | Experimental, Investigational and/or Unproven Procedures/Services | | |
| K1032 | Non Pneum Seq Comp Full Leg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | ADM1001.032 | Experimental, Investigational and/or Unproven Procedures/Services | | |
| 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). | ADM1001.032 | Experimental, Investigational and/or Unproven Procedures/Services | | |
| K1033 | Non Pneum Seq Comp Half Leg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | ADM1001.032 | Experimental, Investigational and/or Unproven Procedures/Services | | |
| L0120 | Cerv flex n/adj foam pre ots | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L0999 | Add to spinal orthosis NOS | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| L1499 | Spinal orthosis NOS | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| L1834 | Ko w/0 joint rigid molded to | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME103.002 | Knee Braces | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME103.002 | Knee Braces | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME103.002 | Knee Braces | _ | _ |
| L1846 | Ko w adj flex/ext rotat mold | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME103.002 | Knee Braces | _ | _ |
| L1860 | Ko supracondylar socket mold | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME103.002 | Knee Braces | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME103.001 | Orthotics | _ | _ |
| L2999 | Lower extremity orthosis NOS | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| L3001 | Foot insert remov molded spe | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3002 | Foot insert plastazote or eq | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3003 | Foot insert silicone gel eac | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3010 | Foot longitudinal arch suppo | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3020 | Foot longitud/metatarsal sup | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3030 | Foot arch support removprem | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3031 | Foot lamin/prepreg composite | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3040 | Ft arch suprt premold longit | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3050 | Foot arch supp premold metat | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3060 | Foot arch supp longitud/meta | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3070 | Arch suprt att to sho longit | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3080 | Arch supp att to shoe metata | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3090 | Arch supp att to shoe long/m | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3100 | Hallus-valgus nt dyn pre ots | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3140 | Abduction rotation bar shoe | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3150 | Abduct rotation bar w/o shoe | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3160 | Shoe styled positioning dev | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3170 | Foot plas heel stabi pre ots | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3201 | Oxford w supinat/pronat inf | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| L3202 | Oxford w/ supinat/pronator c | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3203 | Oxford w/ supinator/pronator | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3204 | Hightop w/ supp/pronator inf | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3206 | Hightop w/ supp/pronator chi | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3207 | Hightop w/ supp/pronator jun | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3212 | Benesch boot pair infant | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3213 | Benesch boot pair child | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3214 | Benesch boot pair junior | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3215 | Orthopedic ftwear ladies oxf | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3216 | Orthoped ladies shoes dpth i | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3217 | Ladies shoes hightop depth i | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3219 | Orthopedic mens shoes oxford | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3221 | Orthopedic mens shoes dpth i | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3222 | Mens shoes hightop depth inl | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3224 | Woman's shoe oxford brace | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3225 | Man's shoe oxford brace | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3230 | Custom shoes depth inlay | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3250 | Custom mold shoe remov prost | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3251 | Shoe molded to pt silicone s | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3252 | Shoe molded plastazote cust | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3253 | Shoe molded plastazote cust | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3254 | Orth foot non-stndard size/w | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3255 | Orth foot non-standard size/ | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3257 | Orth foot add charge split s | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3265 | Plastazote sandal each | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3300 | Sho lift taper to metatarsal | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3310 | Shoe lift elev heel/sole neo | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3320 | Shoe lift elev heel/sole cor | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3330 | Lifts elevation metal extens | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3332 | Shoe lifts tapered to one-ha | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3334 | Shoe lifts elevation heel /i | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3340 | Shoe wedge sach | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3350 | Shoe heel wedge | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3360 | Shoe sole wedge outside sole | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3370 | Shoe sole wedge between sole | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3380 | Shoe clubfoot wedge | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3390 | Shoe outflare wedge | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3400 | Shoe metatarsal bar wedge ro | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3410 | Shoe metatarsal bar between | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3420 | Full sole/heel wedge btween | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3430 | Sho heel count plast reinfor | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3440 | Heel leather reinforced | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3450 | Shoe heel sach cushion type | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3455 | Shoe heel new leather standa | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3460 | Shoe heel new rubber standar | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| L3465 | Shoe heel thomas with wedge | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3470 | Shoe heel thomas extend to b | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3480 | Shoe heel pad & depress for | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3485 | Shoe heel pad removable for | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3500 | Ortho shoe add leather insol | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3510 | Orthopedic shoe add rub insl | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3520 | O shoe add felt w leath insl | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3530 | Ortho shoe add half sole | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3540 | Ortho shoe add full sole | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3550 | O shoe add standard toe tap | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3560 | O shoe add horseshoe toe tap | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3570 | O shoe add instep extension | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3580 | O shoe add instep velcro clo | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3590 | O shoe convert to sof counte | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3595 | Ortho shoe add march bar | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3600 | Trans shoe calip plate exist | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3610 | Trans shoe caliper plate new | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3620 | Trans shoe solid stirrup exi | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3630 | Trans shoe solid stirrup new | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3640 | Shoe dennis browne splint bo | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3649 | Orthopedic shoe modifica NOS | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| L3999 | Upper limb orthosis NOS | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| L5610 | Above knee hydracadence | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5611 | Ak 4 bar link w/fric swing | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5613 | Ak 4 bar ling w/hydraul swig | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5614 | 4-bar link above knee w/swng | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5616 | Ak univ multiplex sys frict | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5620 | Test socket below knee | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5624 | Test socket above knee | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5629 | Below knee acrylic socket | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5631 | Ak/knee disartic acrylic soc | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5638 | Below knee leather socket | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5639 | Below knee wood socket | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| L5640 | Knee disarticulat leather so | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5642 | Above knee leather socket | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5644 | Above knee wood socket | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5645 | Bk flex inner socket ext fra | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5646 | Below knee cushion socket | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5647 | Below knee suction socket | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5648 | Above knee cushion socket | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5651 | Ak flex inner socket ext fra | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5652 | Suction susp ak/knee disart | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5670 | Bk molded supracondylar susp | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5676 | Bk knee joints single axis p | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5704 | Custom shape cover BK | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5705 | Custom shape cover AK | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5706 | Custom shape cvr knee disart | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5710 | Kne-shin exo sng axi mnl loc | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5711 | Knee-shin exo mnl lock ultra | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5712 | Knee-shin exo frict swg & st | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5714 | Knee-shin exo variable frict | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5716 | Knee-shin exo mech stance ph | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5718 | Knee-shin exo frct swg & sta | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5722 | Knee-shin pneum swg frct exo | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5724 | Knee-shin exo fluid swing ph | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| L5726 | Knee-shin ext jnts fld swg e | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5728 | Knee-shin fluid swg & stance | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5780 | Knee-shin pneum/hydra pneum | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5785 | Exoskeletal bk ultralt mater | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5790 | Exoskeletal ak ultra-light m | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5795 | Exoskel hip ultra-light mate | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5810 | Endoskel knee-shin mnl lock | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5811 | Endo knee-shin mnl lck ultra | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5812 | Endo knee-shin frct swg & st | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5814 | Endo knee-shin hydral swg ph | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5816 | Endo knee-shin polyc mch sta | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5818 | Endo knee-shin frct swg & st | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5822 | Endo knee-shin pneum swg frc | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5824 | Endo knee-shin fluid swing p | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5826 | Miniature knee joint | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5828 | Endo knee-shin fluid swg/sta | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5830 | Endo knee-shin pneum/swg pha | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5840 | Multi-axial knee/shin system | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5848 | Knee-shin sys hydraul stance | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5856 | Elec knee-shin swing/stance | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5857 | Elec knee-shin swing only | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5858 | Stance phase only | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| L5859 | Knee-shin pro flex/ext cont | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5961 | Endo poly hip pneu/hyd/rot | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5962 | Below knee flex cover system | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5964 | Above knee flex cover system | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5966 | Hip flexible cover system | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5968 | Multiaxial ankle w dorsiflex | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5970 | Foot external keel sach foot | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5972 | Flexible keel foot | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5974 | Foot single axis ankle/foot | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5976 | Energy storing foot | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5978 | Ft prosth multiaxial ankl/ft | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5980 | Flex foot system | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5982 | Exoskeletal axial rotation u | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5984 | Endoskeletal axial rotation | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5985 | Lwr ext dynamic prosth pylon | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| L5986 | Multi-axial rotation unit | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.001 | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| L6611 | Additional switch ext power | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.001 | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | _ | _ |
| L6621 | Flex/ext wrist w/wo friction | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.001 | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | _ | _ |
| L6715 | Terminal Device Multiple Articulating Digit Includes Motor(S) Initial Issue Or Replacement | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.001 | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | _ | _ |
| L6880 | Electric Hand Switch Or Myolelectric Controlled Independently Articulating Digits Any Grasp Pattern Or Combination Of Grasp Patterns Includes Motor(S) | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.001 | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | _ | _ |
| L6882 | Microprocessor control uplmb | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.001 | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | _ | _ |
| L6920 | Wrist disarticul switch ctrl | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.001 | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | _ | _ |
| L6925 | Wrist disart myoelectronic c | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.001 | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | _ | _ |
| L6930 | Below elbow switch control | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.001 | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | _ | _ |
| L6935 | Below elbow myoelectronic ct | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.001 | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | _ | _ |
| L6940 | Elbow disarticulation switch | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.001 | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | _ | _ |
| L6945 | Elbow disart myoelectronic c | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.001 | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | _ | _ |
| L6950 | Above elbow switch control | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.001 | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | _ | _ |
| L6955 | Above elbow myoelectronic ct | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.001 | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | _ | _ |
| L6960 | Shldr disartic switch contro | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.001 | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | _ | _ |
| L6965 | Shldr disartic myoelectronic | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.001 | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | _ | _ |
| L6970 | Interscapular-thor switch ct | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.001 | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | _ | _ |
| L6975 | Interscap-thor myoelectronic | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.001 | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | _ | _ |
| L7007 | Adult electric hand | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.001 | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| L7008 | Pediatric electric hand | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.001 | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | _ | _ |
| L7009 | Adult electric hook | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.001 | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | _ | _ |
| L7040 | Prehensile actuator | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.001 | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | _ | _ |
| L7045 | Pediatric electric hook | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.001 | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | _ | _ |
| L7170 | Electronic elbow hosmer swit | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.001 | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | _ | _ |
| L7180 | Electronic elbow sequential | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.001 | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | _ | _ |
| L7181 | Electronic elbo simultaneous | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.001 | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | _ | _ |
| L7185 | Electron elbow adolescent sw | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.001 | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | _ | _ |
| L7186 | Electron elbow child switch | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.001 | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | _ | _ |
| L7190 | Elbow adolescent myoelectron | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.001 | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | _ | _ |
| L7191 | Elbow child myoelectronic ct | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.001 | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | _ | _ |
| L7259 | Electronic wrist rotator any | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.001 | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012<br>DME104.001 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics<br>Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012<br>DME104.001 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics<br>Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | _ | _ |
| L7364 | Twelve volt battery utah/equ | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.001 | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | _ | _ |
| L7366 | Battery chrgr 12 volt utah/e | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.001 | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| L7367 | Replacemnt lithium ionbatter | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012<br>DME104.001 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics<br>Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | _ | _ |
| L7368 | Lithium ion battery charger | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.012<br>DME104.001 | Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics<br>Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | _ | _ |
| L7499 | Upper extremity prosthes NOS | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| L7900 | Male vacuum erection system | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.030 | Sexual Dysfunctions, Assessment and Treatment | _ | _ |
| L7902 | Tension Ring Vac Erect Dev | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.030 | Sexual Dysfunctions, Assessment and Treatment | 7/1/2022 | _ |
| 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. | _ | _ | _ | _ |
| L8600 | Implant breast silicone/eq | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR716.009<br>SUR716.011<br>SUR716.010<br>DME104.001 | Mastopexy<br>Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis<br>Breast Implant, Removal and/or Insertion<br>Reconstructive and Contralateral Mammaplasty | _ | _ |
| L8604 | Dextranomer/hyaluronic acid | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR710.022<br>SUR710.008 | Injectable Bulking Agents for the Treatment of Urinary and Fecal Incontinence<br>Periureteral Bulking Agents as a Treatment of Vesicoureteral Reflux (VUR) | _ | _ |
| 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). | SUR710.008 | Injectable Bulking Agents for the Treatment of Urinary and Fecal Incontinence | _ | _ |
| L8606 | Synthetic implnt urinary 1ml | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR710.022<br>SUR710.008 | Injectable Bulking Agents for the Treatment of Urinary and Fecal Incontinence<br>Periureteral Bulking Agents as a Treatment of Vesicoureteral Reflux (VUR) | _ | _ |
| L8607 | Inj vocal cord bulking agent | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001 | Cosmetic and Reconstructive Procedures | _ | _ |
| L8608 | Arg ii ext com/sup/acc misc | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR713.026 | Retinal Prosthesis | _ | _ |
| L8609 | Artificial cornea | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | OTH903.030<br>SUR713.025 | Keratoprosthesis<br>Intraocular Lens (IOLs) and Implantable Miniature Telescope (IMT) | _ | _ |
| L8612 | Aqueous shunt prosthesis | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR713.034 | Aqueous Shunts and Stents for Glaucoma | _ | _ |
| L8614 | Cochlear device | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR714.004 | Cochlear Implant | _ | _ |
| L8615 | Coch implant headset replace | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR714.004 | Cochlear Implant | _ | _ |
| L8616 | Coch implant microphone repl | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR714.004 | Cochlear Implant | _ | _ |
| L8617 | Coch implant trans coil repl | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR714.004 | Cochlear Implant | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| L8618 | Coch implant tran cable repl | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR714.004 | Cochlear Implant | _ | _ |
| L8619 | Coch imp ext proc/contr rplc | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR714.004 | Cochlear Implant | _ | _ |
| L8621 | Repl zinc air battery | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR714.004 | Cochlear Implant | _ | _ |
| L8622 | Repl alkaline battery | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR714.004 | Cochlear Implant | _ | _ |
| L8623 | Lith ion batt CID non-earlvl | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR714.004 | Cochlear Implant | _ | _ |
| L8624 | Lith ion batt cid ear level | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR714.004 | Cochlear Implant | _ | _ |
| L8627 | CID ext speech process repl | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR714.004 | Cochlear Implant | _ | _ |
| L8628 | CID ext controller repl | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR714.004 | Cochlear Implant | _ | _ |
| L8629 | CID transmit coil and cable | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR714.004 | Cochlear Implant | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR712.025<br>MED205.032<br>SUR712.021<br>SUR712.033<br>SUR712.009 | Deep Brain Stimulation (DBS)<br>Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS)<br>Vagus Nerve Stimulation (VNS)<br>Spinal Cord Stimulation (SCS) and Dorsal Root Ganglion (DRG) Stimulation<br>Occipital Nerve Stimulation | _ | _ |
| L8680 | Implt neurostim elctr each | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR710.018<br>SUR712.025<br>SUR709.031<br>MED205.032<br>SUR712.021<br>SUR712.039<br>SUR712.033<br>SUR712.009 | Sacral Nerve Neuromodulation/Stimulation<br>Gastric Electrical Stimulation (GES)<br>Deep Brain Stimulation (DBS)<br>Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS)<br>Vagus Nerve Stimulation (VNS)<br>Spinal Cord Stimulation (SCS) and Dorsal Root Ganglion (DRG) Stimulation<br>Occipital Nerve Stimulation<br>Responsive Neurostimulation (RNS) for the Treatment of Refractory Focal Epilepsy | _ | _ |
| L8681 | Pt prgrm for implt neurostim | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR712.033<br>MED205.036<br>SUR710.018<br>SUR712.021 | Occipital Nerve Stimulation<br>Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS)<br>Sacral Nerve Neuromodulation/Stimulation<br>Vagus Nerve Stimulation (VNS) | _ | _ |
| L8682 | Implt neurostim radiofq rec | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR712.021<br>SUR712.033<br>MED205.032 | Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS)<br>Occipital Nerve Stimulation<br>Vagus Nerve Stimulation (VNS) | _ | _ |
| L8683 | Radiofq trsmtr for implt neu | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR712.021<br>SUR712.033<br>MED205.032 | Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS)<br>Occipital Nerve Stimulation<br>Vagus Nerve Stimulation (VNS) | _ | 12/31/2021 |

| | | | | | |
|---|---|---|---|---|---|
| L8685 | Implt nrostm pls gen sng rec | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR710.018<br>SUR712.025<br>SUR709.031<br>MED205.032<br>SUR712.021<br>SUR712.033<br>SUR712.009 | Sacral Nerve Neuromodulation/Stimulation<br>Gastric Electrical Stimulation (GES)<br>Deep Brain Stimulation (DBS)<br>Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS)<br>Vagus Nerve Stimulation (VNS)<br>Spinal Cord Stimulation (SCS) and Dorsal Root Ganglion (DRG) Stimulation<br>Occipital Nerve Stimulation _ | 12/31/2021 |
| L8686 | Implt nrostm pls gen sng non | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR710.018<br>SUR712.025<br>SUR709.031<br>MED205.032<br>SUR712.021<br>SUR712.039<br>SUR712.033<br>SUR712.009 | Sacral Nerve Neuromodulation/Stimulation<br>Gastric Electrical Stimulation (GES)<br>Deep Brain Stimulation (DBS)<br>Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS)<br>Vagus Nerve Stimulation (VNS)<br>Spinal Cord Stimulation (SCS) and Dorsal Root Ganglion (DRG) Stimulation<br>Occipital Nerve Stimulation<br>Responsive Neurostimulation (RNS) for the Treatment of Refractory Focal Epilepsy _ | 12/31/2021 |
| L8687 | Implt nrostm pls gen dua rec | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR710.018<br>SUR712.025<br>SUR709.031<br>MED205.032<br>SUR712.021<br>SUR712.033<br>SUR712.009 | Sacral Nerve Neuromodulation/Stimulation<br>Gastric Electrical Stimulation (GES)<br>Deep Brain Stimulation (DBS)<br>Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS)<br>Vagus Nerve Stimulation (VNS)<br>Spinal Cord Stimulation (SCS) and Dorsal Root Ganglion (DRG) Stimulation<br>Occipital Nerve Stimulation _ | 12/31/2021 |
| L8688 | Implt nrostm pls gen dua non | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR710.018<br>SUR712.025<br>SUR709.031<br>MED205.032<br>SUR712.021<br>SUR712.039<br>SUR712.033<br>SUR712.009 | Sacral Nerve Neuromodulation/Stimulation<br>Gastric Electrical Stimulation (GES)<br>Deep Brain Stimulation (DBS)<br>Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS)<br>Vagus Nerve Stimulation (VNS)<br>Spinal Cord Stimulation (SCS) and Dorsal Root Ganglion (DRG) Stimulation<br>Occipital Nerve Stimulation<br>Responsive Neurostimulation (RNS) for the Treatment of Refractory Focal Epilepsy _ | 12/31/2021 |

| | | | | | | |
|---|---|---|---|---|---|---|
| L8689 | External recharg sys intern | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR712.033<br>MED205.036<br>SUR712.021 | Occipital Nerve Stimulation Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS) Vagus Nerve Stimulation (VNS) | _ | _ |
| L8690 | Aud osseo dev int/ext comp | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR714.003 | Implantable Bone-Conduction and Bone-Anchored Hearing Aids | _ | _ |
| L8691 | Aoi snd proc repl excl actua | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR714.003 | Implantable Bone-Conduction and Bone-Anchored Hearing Aids | _ | _ |
| L8693 | Aud osseo dev abutment | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR714.003 | Implantable Bone-Conduction and Bone-Anchored Hearing Aids | _ | _ |
| L8694 | Aoi transducer/actuator repl | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR714.003 | Implantable Bone-Conduction and Bone-Anchored Hearing Aids | _ | _ |
| L8695 | External recharg sys extern | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.036 | Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS) | _ | _ |
| L8698 | Misc used with tot art heart | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| L8699 | Prosthetic implant NOS | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| L8701 | Ewh s/d uprt micro sensor | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.001 | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | _ | _ |
| L8702 | Ewhf s/d uprt micro sensor | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME104.001 | Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis | _ | _ |
| M0075 | Cellular therapy | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| M0076 | Prolotherapy | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED201.013 | Prolotherapy | 1/1/2023 | _ |
| M0076 | Prolotherapy | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | MED201.013 | Prolotherapy | _ | Moved to PA list |
| M0076 | Prolotherapy | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.013 | Prolotherapy | 10/1/2022 | 12/31/2022 |
| M0100 | Intragastric hypothermia | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| M0300 | IV chelationtherapy | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE801.008 | Chelation Therapy | _ | _ |
| P2031 | Hair analysis | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | PSY301.014 | Autism Spectrum Disorders (ASD) | _ | _ |
| P9020 | Plaelet rich plasma unit | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | RX501.034<br>RX501.101 | Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions Orthopedic Applications of Platelet-Rich Plasma | _ | _ |
| P9099 | Blood component/product noc | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| Q0035 | Cardiokymography | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| Q0114 | Fern test | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| Q0115 | Post-coital mucous exam | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| Q0243 | casirivimab and imdevimab | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| Q0244 | Casirivi and imdevi 1200 mg | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | 6/3/2021 | _ |
| Q0245 | bamlanivimab and etesevima | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | 2/9/2021 | _ |
| Q0477 | Pwr module pt cable lvad rpl | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| Q0478 | Power adapter combo vad | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| Q0479 | Power module combo vad rep | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| Q0480 | Driver pneumatic vad rep | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| Q0481 | Microprcsr cu elec vad rep | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| Q0482 | Microprcsr cu combo vad rep | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| Q0483 | Monitor elec vad rep | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| Q0484 | Monitor elec or comb vad rep | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| Q0485 | Monitor cable elec vad rep | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| Q0486 | Mon cable elec/pneum vad rep | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| Q0487 | Leads any type vad rep only | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| Q0488 | Pwr pack base elec vad rep | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| Q0489 | Pwr pck base combo vad rep | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| Q0490 | Emr pwr source elec vad rep | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| Q0491 | Emr pwr source combo vad rep | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| Q0492 | Emr pwr cbl elec vad rep | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| Q0493 | Emr pwr cbl combo vad rep | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| Q0494 | Emr hd pmp elec/combo rep | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| Q0495 | Charger elec/combo vad rep | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| Q0496 | Battery elec/combo vad rep | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| Q0497 | Bat clps elec/comb vad rep | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| Q0498 | Holster elec/combo vad rep | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| Q0502 | Mobility cart pneum vad rep | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| Q0503 | Battery pneum vad replacemnt | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| Q0506 | Lith-ion batt elec/pneum VAD | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| Q0507 | Misc sup/acc ext VAD | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| Q0508 | Misc sup/acc imp VAD | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| Q0509 | Mis sup/ac imp VAD nopay med | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.017 | Ventricular Assist Devices and Total Artificial Hearts | _ | _ |
| Q2026 | Radiesse injection | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001 | Cosmetic and Reconstructive Procedures | _ | _ |
| Q2028 | Inj sculptra 0.5mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.001 | Cosmetic and Reconstructive Procedures | _ | _ |
| Q2039 | Influenza virus vaccine nos | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| Q2041 | Axicabtagene ciloleucel car+ | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | _ | _ |
| Q2043 | Sipuleucel-T, Minimum Of 50 Million Autologous Cd54+ Cells Activated With Pap-Gm-Csf, Including Leukapheresis And All Other Preparatory Procedures, Per Infusion | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.074 | Cellular Immunotherapy for Prostate Cancer (Sipuleucel-T [Provenge]) | _ | Moved to PA list |
| Q2050 | Doxorubicin inj 10mg | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. May require Prior Authorization based on contract agreement. | _ | _ | _ | _ |
| Q2052 | Ivig demo services/supplies | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| Q2053 | Brexucabtagene autoleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX502.061 | Oncology Medications | 4/1/2021 | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX502.061 | Oncology Medications | 10/1/2021 | _ |
| Q2055 | Idecabtagene vicleucel car | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | N/A | N/A | 1/1/2022 | _ |
| Q2056 | Ciltacabtagene car-pos t | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX502.061 | Oncology Medications | 10/1/2022 | |
| Q4050 | Cast supplies unlisted | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| Q4051 | Splint supplies misc | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| Q4082 | Drug/bio NOC part B drug CAP | Non Covered: Procedure/service not covered by BCBSOK. 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 2/1/2021 | _ |
| Q4101 | Apligraf | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 2/1/2021 | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| Q4102 | Oasis wound matrix | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 2/1/2021 _ | |
| 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). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 5/15/2021 _ | |
| 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). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 5/15/2021 _ | |
| Q4105 | Integra drt or omnigraft | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 2/1/2021 _ | |
| Q4106 | Dermagraft | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 2/1/2021 _ | |
| Q4107 | Graftjacket | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 2/1/2021 _ | |
| Q4108 | Integra matrix | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 2/1/2021 _ | |
| Q4110 | Primatrix | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 5/15/2021 _ | |
| Q4111 | Gammagraft | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 5/15/2021 _ | |
| 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). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 5/15/2021 _ | |
| 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). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 5/15/2021 _ | |
| Q4114 | Integra flowable wound matri | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 2/1/2021 _ | |
| Q4115 | Alloskin | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 5/15/2021 _ | |
| Q4116 | Alloderm | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 2/1/2021 _ | |
| Q4117 | Hyalomatrix | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 5/15/2021 _ | |
| Q4118 | Matristem micromatrix | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 5/15/2021 _ | |
| Q4121 | Theraskin | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 5/15/2021 _ | |
| Q4122 | Dermacell awm porous 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). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 4/1/2021 | 10/14/2021 |
| Q4122 | Dermacell awm porous sq cm | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 10/15/2021 _ | |
| Q4123 | Alloskin Rt Per Square Centimeter | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 5/15/2021 _ | |
| Q4124 | Oasis Ultra Tri-Layer Wound Matrix Per Square Centimeter | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 5/15/2021 _ | |
| Q4125 | Arthroflex Per Square Centimeter | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 5/15/2021 _ | |
| Q4126 | Memoderm/derma/tranz/integup | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 5/15/2021 _ | |
| Q4127 | Talymed Per Square Centimeter | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 5/15/2021 _ | |
| Q4128 | Flexhd/Allopatchhd/matrixhd | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 2/1/2021 _ | |
| 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). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 5/15/2021 _ | |
| Q4132 | Grafix core grafixpl core | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 5/15/2021 _ | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Q4133 | Grafix stravix prime pl sqcm | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 5/15/2021 | _ |
| 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). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 5/15/2021 | _ |
| Q4135 | Mediskin | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 5/15/2021 | _ |
| Q4136 | EZderm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 5/15/2021 | _ |
| Q4137 | Amnioexcel biodexcel 1sq cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 5/15/2021 | _ |
| 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). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 5/15/2021 | _ |
| 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). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 5/15/2021 | _ |
| Q4140 | Biodfence 1cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 5/15/2021 | _ |
| Q4141 | Alloskin ac 1 cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 5/15/2021 | _ |
| Q4142 | Xcm biologic tiss matrix 1cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 5/15/2021 | _ |
| 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). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 5/15/2021 | _ |
| Q4145 | Epifix inj 1mg | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 5/15/2021 | _ |
| Q4146 | Tensix 1cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 5/15/2021 | _ |
| Q4147 | Architect ecm px fx 1 sq cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 5/15/2021 | _ |
| 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). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 5/15/2021 | _ |
| Q4149 | Excellagen 0.1 cc | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 5/15/2021 | _ |
| Q4150 | Allowrap ds or dry 1 sq cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | _ |
| Q4151 | Amnioband guardian 1 sq cm | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | _ |
| 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). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 5/15/2021 | _ |
| Q4153 | Dermavest plurivest sq cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 5/15/2021 | _ |
| Q4154 | Biovance 1 square cm | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 5/15/2021 | _ |
| Q4155 | Neoxflo or clarixflo 1 mg | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 5/15/2021 | _ |
| 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). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 5/15/2021 | _ |
| 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). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 5/15/2021 | _ |
| 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). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 5/15/2021 | _ |
| Q4159 | Affinity1 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). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 5/15/2021 | 1/31/2022 |
| Q4159 | Affinity1 square cm | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 2/1/2022 | _ |
| 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). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | _ |
| 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). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | 5/15/2021 | _ |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 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). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| Q4163 | Woundex bioskin per sq cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| 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). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | | 5/15/2021 | _ |
| 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). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | | 5/15/2021 | _ |
| 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). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | | 5/15/2021 | _ |
| Q4167 | Truskin per sq centimeter | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | | 5/15/2021 | _ |
| Q4168 | Amnioband 1 mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| 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). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| 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). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| Q4171 | Interfyl 1 mg | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| Q4173 | Palingen or palingen xplus | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| 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). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| Q4175 | Miroderm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | | 4/1/2021 | _ |
| Q4176 | Neopatch Or Therion Per Square Centimeter | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| Q4177 | Floweramnioflo 0.1 cc | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| 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). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| Q4179 | Flowerderm per sq cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | | 5/15/2021 | _ |
| Q4180 | Revita per sq cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| Q4181 | Amnio wound per square cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| 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). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | | 5/15/2021 | _ |
| Q4182 | Transcyte per sq centimeter | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | _ | | 5/14/2021 |
| Q4183 | Surgigraft 1 sq cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| Q4184 | Cellesta or duo per sq cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| Q4185 | Cellesta flowab amnion 0.5cc | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| Q4186 | Epifix 1 sq cm | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| Q4187 | Epicord 1 sq cm | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| 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). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| Q4189 | Artacent ac 1 mg | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| Q4190 | Artacent ac 1 sq cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 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). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| 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). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| Q4193 | Coll-e-derm 1 sq cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | | 3/1/2021 | _ |
| Q4194 | Novachor 1 sq cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| Q4195 | Puraply 1 sq cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | | 5/15/2021 | _ |
| 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). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | | 5/15/2021 | _ |
| 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). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | _ | | _ |
| Q4198 | Genesis amnio membrane 1sqcm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| Q4199 | Cygnus matrix per sq cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | | 4/15/2022 | _ |
| Q4199 | Cygnus matrix per sq cm | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.011 | Amniotic Membrane and Amniotic Fluid | | 1/1/2022 | 4/14/2022 |
| Q4200 | Skin te 1 sq cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | | 3/1/2021 | _ |
| 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). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| Q4202 | Keroxx (2.5g/cc) 1cc | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | | 3/1/2021 | _ |
| Q4203 | Derma-gide 1 sq cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | | 3/1/2021 | _ |
| Q4204 | Xwrap 1 sq cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| Q4205 | Membrane graft or wrap sq cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| 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). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| 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). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| 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). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| Q4210 | Axolotl graf dualgraf sq cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| Q4211 | Amnion bio or axobio sq cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| 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). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| 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). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| 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). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| Q4215 | Axolotl ambient cryo 0.1 mg | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| Q4216 | Artacent cord per sq cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| 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). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| 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). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| 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). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| Q4220 | Bellacell HD Surederm sq cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | | 3/1/2021 | _ |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Q4221 | Amniowrap2 per sq cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| 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). | SUR704.012 | Bioengineered Skin and Soft Tissue Substitutes | | 3/1/2021 | _ |
| 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). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | | | |
| Q4224 | Hhf10-P Per Sq Cm | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.011 | Amniotic Membrane and Amniotic Fluid | | | |
| Q4225 | Amniobind Per Sq Cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | | | |
| Q4225 | Amniobind Per Sq Cm | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.011 | Amniotic Membrane and Amniotic Fluid | | | |
| Q4227 | Amniocore per sq cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| Q4228 | Bionextpatch 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). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | 9/30/2021 |
| Q4229 | Cogenex amnio memb per sq cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| 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). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| 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). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| Q4232 | Corplex per sq cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| Q4233 | Surfactor /nudyn per 0.5 cc | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| Q4234 | Xcellerate per sq cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| 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). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| 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). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | 9/30/2021 |
| Q4237 | Cryo-cord per sq cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| Q4238 | Derm-maxx per sq cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | | 7/1/2022 | _ |
| Q4238 | Derm-maxx per sq cm | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | 6/30/2022 |
| Q4239 | Amnio-maxx or lite per sq cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| Q4240 | Corecyte topical only 0.5 cc | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| Q4241 | Polycyte topical only 0.5cc | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| Q4242 | Amniocyte plus per 0.5 cc | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| Q4244 | Procenta per 200 mg | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| Q4245 | Amniotext per cc | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| Q4246 | Coretext or protext per cc | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| Q4247 | Amniotext patch per sq cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| Q4248 | Dermacyte amn mem allo sq cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | _ | | _ |
| Q4249 | Amniply per sq cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | | 3/1/2021 | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| Q4250 | Amnioamp-mp per sq cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 3/1/2021 _ | |
| Q4251 | Vim per square centimeter | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 1/1/2022 | 1/31/2022 |
| Q4251 | Vim per square centimeter | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 4/15/2022 _ | |
| Q4251 | Vim per square centimeter | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 10/1/2021 | 12/31/2021 |
| Q4251 | Vim per square centimeter | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 2/1/2022 | 4/15/2022 |
| Q4252 | Vendaje per square centimet | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 1/1/2022 | 1/31/2022 |
| Q4252 | Vendaje per square centimet | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 4/15/2022 _ | |
| Q4252 | Vendaje per square centimet | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 10/1/2021 | 12/31/2021 |
| Q4252 | Vendaje per square centimet | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 2/1/2022 | 4/15/2022 |
| Q4253 | Zenith amniotic membrane psc | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 1/1/2022 | 12/31/2021 |
| Q4253 | Zenith amniotic membrane psc | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 4/15/2022 _ | |
| Q4253 | Zenith amniotic membrane psc | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 10/1/2021 | 12/31/2021 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Q4253 | Zenith amniotic membrane psc | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 2/1/2022 | 4/15/2022 |
| Q4254 | Novafix dl per sq cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 4/15/2022 | _ |
| Q4255 | Reguard topical use per sq | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 3/1/2021 | _ |
| Q4256 | Mlg Complet Per Sq Cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | | |
| Q4256 | Mlg Complet Per Sq Cm | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.011 | Amniotic Membrane and Amniotic Fluid | | |
| Q4257 | Relese Per Sq Cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | | |
| Q4257 | Relese Per Sq Cm | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.011 | Amniotic Membrane and Amniotic Fluid | | |
| Q4258 | Enverse Per Sq Cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | | |
| Q4258 | Enverse Per Sq Cm | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.011 | Amniotic Membrane and Amniotic Fluid | | |
| Q4259 | Celera Per Sq Cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 1/1/2023 | |
| Q4259 | Celera Per Sq Cm | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 7/1/2022 | 12/31/2022 |
| Q4260 | Signature Apatch Per Sq Cm | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 1/1/2023 | |
| Q4260 | Signature Apatch Per Sq Cm | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 7/1/2022 | 12/31/2022 |
| Q4261 | Tag Per Square Centimeter | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 1/1/2023 | |
| Q4261 | Tag Per Square Centimeter | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR704.011 | Amniotic Membrane and Amniotic Fluid | 7/1/2022 | 12/31/2022 |
| Q5009 | Hospice care NOS | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| Q5103 | Injection inflectra | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.051<br>RX501.096 | Infliximab and Associated Biosimilars<br>Specialty Medication<br>Administration Site of Care | _ | _ |
| Q5104 | Injection renflexis | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.051<br>RX501.096 | Infliximab and Associated Biosimilars<br>Specialty Medication<br>Administration Site of Care | _ | _ |
| Q5106 | Inj retacrit non-esrd use | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.069 | Erythropoiesis-Stimulating Agents (ESAs) | _ | Moved to PA list |
| Q5107 | Inj mvasi 10 mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | _ | Moved to PA list |
| Q5109 | Injection ixifi 10 mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.051 | Infliximab and Associated Biosimilars | _ | _ |
| Q5115 | Inj truxima 10 mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.030 | Rituximab and Biosimilars for Non-Oncologic Indications | _ | Moved to PA list |
| Q5118 | Inj. zirabev 10 mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.061 | Oncology Medications | _ | Moved to PA list |
| Q5119 | Inj ruxience 10 mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | Oncology Medications | RX502.061 | _ | Moved to PA list |
| Q5123 | Inj. Riabni 10 Mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX502.030 | Rituximab and Biosimilars for Non-Oncologic Indications | 7/1/2021 | Moved to PA list |
| Q5124 | Inj. Byooviz 0.1 Mg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | OTH903.041 | Ranibizumab Injections, Implants and Biosimilars | | |
| Q5125 | Inj releuko 1 mcg | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.134 | Oncologic Uses of White Blood Cell Colony Stimulating Factors | 10/1/2022 | |

| | | | | | |
|---|---|---|---|---|---|
| Q9004 | Va whole health partner serv | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | N/A | N/A | 10/1/2021 |
| Q9982 | flutemetamol f18 diagnostic | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | N/A | N/A | |
| Q9983 | florbetaben f18 diagnostic | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | N/A | N/A | |
| S0013 | Esketamine nasal spray | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.105 | Esketamine Nasal Spray | 2/1/2021 |
| S0122 | Inj menotropins 75 iu | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | |
| S0126 | Inj follitropin alfa 75 iu | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | |
| S0128 | Inj follitropin beta 75 iu | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | |
| S0155 | Epoprostenol dilutant | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.056 | Advanced Therapies for Pharmacologic Treatment of Pulmonary Hypertension | |
| S0157 | Becaplermin gel 1% 0.5 gm | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.034 | Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions | |
| S0189 | Testosterone pellet 75 mg | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | RX501.007<br>SUR717.001<br>RX501.076 | Gender Assignment Surgery and Gender Reassignment Surgery with Related Services<br>Testosterone Replacement Therapies<br>Hormone Replacement Therapies (HRT) Using Implanted Pellets for Women and Delayed Puberty | 5/15/2010 |
| S0194 | Dialysis/Stress Vitamin Supplement Oral100 Capsules | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | |
| S0197 | Prenatal vitamins 30 day | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | |
| S0207 | Paramedicintercep nonhospals | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | |
| S0209 | WC van mileage per mi | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | ADM1001.005 | Ambulance and Medical Transport Services | |
| S0215 | Nonemerg transp mileage | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | ADM1001.005 | Ambulance and Medical Transport Services | |
| S0257 | End of life counseling | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | |
| S0315 | Disease management program | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | |
| S0316 | Follow-up/reassessment | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | |
| S0317 | Disease mgmt per diem | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | |
| S0320 | RN telephone calls to DMP | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | |
| S0390 | Rout foot care per visit | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.006 | Foot Care Services | |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR713.025 | Intraocular Lens (IOLs) and Implantable Miniature Telescope (IMT) | |
| S0622 | Phys exam for college | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | |
| S0800 | Laser in situ keratomileusis | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR713.001 | Refractive and Therapeutic Keratoplasty | |
| S0810 | Photorefractive keratectomy | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | SUR713.001 | Refractive and Therapeutic Keratoplasty | 1/1/2021 |

| | | | | | | |
|---|---|---|---|---|---|---|
| S0812 | Phototherap keratect | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR713.023 | Phototherapeutic Keratectomy | _ | _ |
| S1001 | Deluxe item | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| S1002 | Custom item | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |
| S1030 | Gluc monitor purchase | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.005 | Glucose Monitoring and Insulin Delivery Devices for Managing Diabetes | _ | _ |
| S1031 | Gluc monitor rental | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.005 | Glucose Monitoring and Insulin Delivery Devices for Managing Diabetes | _ | _ |
| S1034 | Art pancreas system | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.005 | Glucose Monitoring and Insulin Delivery Devices for Managing Diabetes | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.005 | Glucose Monitoring and Insulin Delivery Devices for Managing Diabetes | _ | _ |
| S1036 | Art pancreas ext transmitter | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.005 | Glucose Monitoring and Insulin Delivery Devices for Managing Diabetes | _ | _ |
| S1037 | Art pancreas ext receiver | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.005 | Glucose Monitoring and Insulin Delivery Devices for Managing Diabetes | _ | _ |
| S1040 | Cranial remolding orthosis | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME103.007 | Adjustable Cranial Orthoses for Positional Plagiocephaly and Craniosynostoses | _ | _ |
| S1091 | Stent Non-Coronary Propel | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR706.001 | Nasal and Sinus Surgery | 5/15/2021 | _ |
| S2080 | Laup | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR706.009 | Sleep Related Breathing Disorders: Surgical Management | _ | _ |
| S2083 | Adjustment gastric band | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR716.003 | Bariatric Surgery | _ | _ |
| S2095 | Transcath emboliz microspher | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RAD601.047 | Radioembolization for Primary and Metastatic Tumors of the Liver | _ | _ |
| S2102 | Islet cell tissue transplant | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR703.013 | Pancreas and Related Organ Tissue Transplantation | _ | _ |
| S2103 | Adrenal tissue transplant | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR703.003 | Brain Tissue Transplantation, Neurotransplantation for Treatment of Parkinsons Disease | _ | _ |
| S2107 | Adoptive immunotherapy | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE801.024 | Adoptive Immunotherapy | _ | _ |
| S2112 | Knee arthroscp harv | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR705.035 | Autologous Chondrocyte Implantation (ACI) for Focal Articular Cartilage Lesions | _ | _ |
| 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). | SUR705.027 | Subtalar Arthroereisis (STA) | _ | _ |
| S2118 | Total hip resurfacing | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | SUR705.019 | Hip Resurfacing (HR) | _ | Moved to PA list |
| S2120 | Low density lipoprotein(LDL) | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | THE802.003 | Lipid Apheresis | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| S2140 | | | | Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)<br>Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors<br>Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas<br>Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) | | |
| | | | SUR703.042<br>SUR703.033<br>SUR703.030<br>SUR703.037<br>SUR703.038<br>SUR703.034<br>SUR703.046<br>SUR703.050<br>SUR703.041<br>SUR703.036<br>SUR703.047<br>SUR703.029<br>SUR703.032<br>SUR703.031<br>SUR703.043<br>SUR703.045<br>SUR703.035<br>SUR703.040<br>SUR703.002<br>SUR703.044 | Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML)<br>Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer<br>Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma<br>Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL)<br>Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) | | |
| | Cord blood harvesting | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR703.039 | Hematopoietic Cell | _ | _ |
| S2142 | | | | Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)<br>Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors<br>Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas<br>Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) | | |
| | | | SUR703.042<br>SUR703.033<br>SUR703.030<br>SUR703.037<br>SUR703.038<br>SUR703.034<br>SUR703.046<br>SUR703.050<br>SUR703.041<br>SUR703.036<br>SUR703.047<br>SUR703.029<br>SUR703.032<br>SUR703.031<br>SUR703.043<br>SUR703.045<br>SUR703.035<br>SUR703.040<br>SUR703.002<br>SUR703.044 | Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML)<br>Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer<br>Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma<br>Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL)<br>Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) | | |
| | Cord blood-derived stem-cell | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR703.039 | Hematopoietic Cell | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR703.042<br>SUR703.033<br>SUR703.030<br>SUR703.037<br>SUR703.038<br>SUR703.034<br>SUR703.046<br>SUR703.050<br>SUR703.041<br>SUR703.036<br>SUR703.047<br>SUR703.029<br>SUR703.032<br>SUR703.031<br>SUR703.043<br>SUR703.045<br>SUR703.035<br>SUR703.040<br>SUR703.002<br>SUR703.044<br>SUR703.039 | Hematopoietic Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)<br>Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors<br>Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas<br>Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML)<br>Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML)<br>Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer<br>Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma<br>Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL)<br>Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information)<br>Hematopoietic Cell | _ | _ |
| S2202 | Echosclerotherapy | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.016 | Varicose Vein Management | _ | _ |
| S2205 | Minimally invasive direct co | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.020 | Minimally Invasive Coronary Artery Bypass Graft Surgery | _ | 7/31/2022 |
| S2206 | Minimally invasive direct co | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.020 | Minimally Invasive Coronary Artery Bypass Graft Surgery | _ | 7/31/2022 |
| S2207 | Minimally invasive direct co | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.020 | Minimally Invasive Coronary Artery Bypass Graft Surgery | _ | 7/31/2022 |
| S2208 | Minimally invasive direct co | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.020 | Minimally Invasive Coronary Artery Bypass Graft Surgery | _ | 7/31/2022 |
| S2209 | Minimally invasive direct co | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR707.020 | Minimally Invasive Coronary Artery Bypass Graft Surgery | _ | 7/31/2022 |
| S2230 | Implant semi-imp hear | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR714.008 | Semi-Implantable and Fully Implantable Middle Ear Hearing Aids | _ | _ |
| S2235 | Implant auditory brain imp | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR714.009 | Auditory Brainstem Implant | _ | _ |
| 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). | SUR705.041 | Thermal Capsulorrhaphy as a Treatment of Joint Instability | _ | _ |
| S2348 | Decompress disc RF lumbar | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR712.037 | Decompression of the Intervertebral Disc Using Laser Energy (Laser Discectomy) or Radiofrequency Coblation (Nucleoplasty) | _ | _ |
| S2400 | Fetal surg congen hernia | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.016 | Fetal Surgery for Prenatally Diagnosed Malformations | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.016 | Fetal Surgery for Prenatally Diagnosed Malformations | _ | _ |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.016 | Fetal Surgery for Prenatally Diagnosed Malformations | _ | | _ |
| S2403 | Fetal surg pulmon sequest | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.016 | Fetal Surgery for Prenatally Diagnosed Malformations | _ | | _ |
| S2404 | Fetal surg myelomeningo | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.016 | Fetal Surgery for Prenatally Diagnosed Malformations | _ | | _ |
| S2405 | Fetal surg sacrococ teratoma | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.016 | Fetal Surgery for Prenatally Diagnosed Malformations | _ | | _ |
| S2409 | Fetal surg noc | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.016 | Fetal Surgery for Prenatally Diagnosed Malformations | _ | | _ |
| S2411 | Fetoscop laser ther TTTS | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR701.016 | Fetal Surgery for Prenatally Diagnosed Malformations | 12/1/2022 | | _ |
| 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). | MED207.128 | Salivary Hormone Testing | _ | | _ |
| S3652 | Saliva test hormone level; | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED207.128 | Salivary Hormone Testing | _ | | _ |
| S3655 | Antisperm antibodies test | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | | _ |
| S3722 | Dose Optimization By Area Under The Curve (Auc) Analysis, For Infusional 5-Fluorouracil | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | #N/A | #N/A | _ | | _ |
| S3800 | Genetic testing ALS | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | | Moved to PA list |
| S3840 | DNA analysis RET-oncogene | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | | Moved to PA list |
| S3841 | Gene test retinoblastoma | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | | Moved to PA list |
| S3842 | Gene test Hippel-Lindau | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | | Moved to PA list |
| S3844 | DNA analysis deafness | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | | Moved to PA list |
| S3845 | Gene test alpha-thalassemia | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | | Moved to PA list |
| S3846 | Gene test beta-thalassemia | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | | Moved to PA list |
| S3849 | Gene test Niemann-Pick | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | | Moved to PA list |
| S3850 | Gene test sickle cell | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | | Moved to PA list |
| S3852 | DNA analysis APOE alzheimer | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | | Moved to PA list |
| S3853 | Gene test myo musclr dyst | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | | Moved to PA list |
| S3854 | Gene profile panel breast | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | MED208.090 | EndoPredict for Breast Cancer Prognosis | _ | | Moved to PA list |
| S3861 | Genetic test brugada | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | | Moved to PA list |
| S3865 | Comp genet test hyp cardiomy | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | | Moved to PA list |
| S3866 | Spec gene test hyp cardiomy | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | | Moved to PA list |
| S3870 | Cgh test developmental delay | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | | Moved to PA list |
| 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). | MED205.006 | Surface Scanning Electromyography (EMG) (SEMG), Paraspinal Surface EMG, and Spinoscopy | _ | | _ |
| 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 BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| S4016 | Frozen IVF case rate | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| S4017 | IVF canc a stim case rate | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| S4018 | F EMB trns canc case rate | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| S4020 | IVF canc a aspir case rate | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| S4021 | IVF canc p aspir case rate | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| S4022 | Asst oocyte fert case rate | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| S4023 | Incompl donor egg case rate | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| S4025 | Donor serv IVF case rate | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| S4026 | Procure donor sperm | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| S4027 | Store prev froz embryos | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| S4028 | Microsurg epi sperm asp | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| S4030 | Sperm procure init visit | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| S4031 | Sperm procure subs visit | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| S4035 | Stimulated IUI case rate | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| S4037 | Cryo embryo transf case rate | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| S4040 | Monit store cryo embryo 30 d | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| S4042 | Ovulation mgmt per cycle | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| S4990 | Nicotine patch legend | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| S4991 | Nicotine patch nonlegend | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| S4995 | Smoking cessation gum | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| S5100 | Adult daycare services 15min | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| S5101 | Adult day care per half day | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| S5102 | Adult day care per diem | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| S5105 | Centerbased day care perdiem | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| S5108 | Homecare train pt 15 min | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| S5109 | Homecare train pt session | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| S5110 | Family homecare training 15m | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| S5111 | Family homecare train/sessio | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| S5115 | Nonfamily homecare train/15m | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| S5116 | Nonfamily HC train/session | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| S5120 | Chore services per 15 min | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| S5121 | Chore services per diem | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| S5125 | Attendant care service /15m | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| S5126 | Attendant care service /diem | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| S5130 | Homaker service nos per 15m | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| S5131 | Homemaker service nos /diem | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| S5135 | Adult companioncare per 15m | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| S5136 | Adult companioncare per diem | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| S5140 | Adult foster care per diem | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| S5141 | Adult foster care per month | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| S5145 | Child fostercare th per diem | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| S5146 | Ther fostercare child /month | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ | |
| S5150 | Unskilled respite care /15m | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ | |
| S5151 | Unskilled respitecare /diem | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ | |
| S5160 | Emer response sys instal&tst | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ | |
| S5161 | Emer rspns sys serv permonth | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ | |
| S5162 | Emer rspns system purchase | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ | |
| S5165 | Home modifications per serv | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ | |
| S5170 | Homedelivered prepared meal | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ | |
| S5175 | Laundry serv ext prof /order | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ | |
| S5181 | HH respiratory thrpy nos/day | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ | |
| S5185 | Med reminder serv per month | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ | |
| S5199 | Personal care item nos each | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ | |
| S5497 | HIT cath care noc | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ | |
| S8030 | Tantalum ring application | Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website. | AIM Guidelines | _ | _ | Moved to PA list | |
| S8035 | Magnetic source imaging | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RAD601.038<br>PSY301.014 | Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI) Autism Spectrum Disorders (ASD) | _ | _ | |
| S8040 | Topographic brain mapping | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.040<br>MED205.009 | Quantitative Electroencephalography (QEEG) as a Diagnostic Aid for Attention-Deficit Hyperactivity Disorder (ADHD) Topographic Brain Mapping (Quantitative Electroencephalography) | _ | _ | |
| S8080 | Scintimammography | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | N/A | N/A | _ | _ | |
| S8092 | Electron beam computed tomog | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RAD604.009 | Computed Tomography to Detect Coronary Artery Calcification | _ | | 12/31/2021 |
| S8130 | Interferential Current Stimulator 2 Channel | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED201.041 | Interferential Current Stimulation | _ | _ | |
| S8131 | Interferential Current Stimulator 4 Channel | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED201.041 | Interferential Current Stimulation | _ | _ | |
| S8185 | Flutter device | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.027 | Airway Clearance Devices | _ | _ | |
| S8189 | Trach supply noc | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ | |
| S8270 | Enuresis alarm | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ | |
| S8301 | Infect control supplies NOS | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ | |
| S8450 | Splint digit | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME103.001 | Orthotics | _ | | 6/30/2022 |
| S8451 | Splint wrist or ankle | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME103.001 | Orthotics | _ | | 6/30/2022 |
| S8452 | Splint elbow | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME103.001 | Orthotics | _ | | 6/30/2022 |
| S8930 | Auricular electrostimulation | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | SUR702.019 | Cranial Electrotherapy Stimulation and Auricular Electrostimulation | _ | _ | |
| S8940 | Hippotherapy per session | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | THE803.022 | Hippotherapy | _ | _ | |

| | | | | | | |
|---|---|---|---|---|---|---|
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED205.022<br>MED201.045<br>THE801.028<br>SUR702.005 | Low-Level and High-Power Laser Therapy<br>Acupuncture for Pain Management, Nausea and Vomiting and Opioid Dependence<br>Treatment of Tinnitus<br>Acne Management | _ | _ |
| S8990 | Pt or manip for maint | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE803.010 | Physical Therapy (PT) and Occupational Therapy (OT) Services | _ | _ |
| S9001 | Home uterine monitor with or | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | OB401.017 | Home Uterine Activity Monitoring | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.034 | Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions | _ | _ |
| S9056 | Coma stimulation per diem | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | MED205.014 | Sensory Stimulation for Coma Patients | _ | _ |
| S9090 | Vertebral axial decompressio | EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). | THE803.021 | Non-Surgical Spinal Decompression Traction Devices | _ | _ |
| S9117 | Back school visit | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE803.024 | Back School | _ | _ |
| S9125 | Respite care in the home p | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | _ | _ | _ | _ |
| S9128 | Speech therapy in the home | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | PSY301.014<br>THE803.014 | Speech-Language Therapy (SLT)<br>Autism Spectrum Disorders (ASD) | _ | _ |
| S9129 | Occupational therapy in the | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | PSY301.014 | Autism Spectrum Disorders (ASD) | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | PSY301.014 | Autism Spectrum Disorders (ASD) | _ | _ |
| S9145 | Insulin pump initiation | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | DME101.005 | Glucose Monitoring and Insulin Delivery Devices for Managing Diabetes | _ | _ |
| S9335 | HT hemodialysis diem | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE802.002 | Daily Hemodialysis and Hemodialysis in the Home Setting | _ | _ |
| S9340 | HIT enteral per diem | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.011 | Nutritional Support | _ | _ |
| S9341 | HIT enteral grav diem | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.011 | Nutritional Support | _ | _ |
| S9342 | HIT enteral pump diem | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.011 | Nutritional Support | _ | _ |
| S9343 | HIT enteral bolus nurs | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.011 | Nutritional Support | _ | _ |
| S9355 | HIT chelation diem | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE801.008<br>PSY301.014 | Chelation Therapy<br>Autism Spectrum Disorders (ASD) | _ | _ |
| S9364 | HIT tpn total diem | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.011 | Nutritional Support | _ | _ |
| S9366 | HIT tpn 2 liter diem | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.011 | Nutritional Support | _ | _ |
| 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 predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.011 | Nutritional Support | _ | _ |
| S9368 | HIT tpn over 3l diem | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.011 | Nutritional Support | _ | _ |
| S9379 | HIT noc per diem | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | _ | _ | _ | _ |

| | | | | | | |
|---|---|---|---|---|---|---|
| S9381 | HIT high risk/escort | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| S9401 | Anticoag clinic per session | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| S9430 | Pharmacy comp/disp serv | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.063 | Compounded Drug Products | | |
| S9432 | Med food non inborn err meta | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | N/A | N/A | 10/1/2021 | |
| S9434 | Mod solid food suppl | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| S9435 | Medical foods for inborn err | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.011 | Nutritional Support | | |
| S9436 | Lamaze class | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| S9437 | Childbirth refresher class | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| S9438 | Cesarean birth class | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| S9439 | VBAC class | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| S9441 | Asthma education | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| S9442 | Birthing class | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| S9444 | Parenting class | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| S9445 | PT education noc individ | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| S9446 | PT education noc group | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| S9447 | Infant safety class | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| S9449 | Weight mgmt class | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| S9451 | Exercise class | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| S9454 | Stress mgmt class | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| S9472 | Cardiac rehabilitation progr | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE803.023 | Cardiac Rehabilitation (CR) | | |
| S9473 | Pulmonary rehabilitation pro | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | THE803.025 | Pulmonary Rehabilitation | | |
| S9482 | Family stabilization 15 min | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| S9537 | HT hem horm inj diem | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.069 | Erythropoiesis-Stimulating Agents (ESAs) | | |
| S9542 | HT inj noc per diem | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | | | | |
| S9558 | HT inj growth horm diem | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.040 | Human Growth Hormone (GH) | | |
| S9560 | HT inj hormone diem | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX501.041 | Gonadotropin-Releasing Hormone (GnRH) Agonists and Antagonists | | |
| S9562 | HT inj palivizumab diem | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | RX504.009 | Respiratory Syncytial Virus (RSV) Immunoprophylaxis | | |
| S9810 | HT pharm per hour | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | MED201.011 | Nutritional Support | | |
| S9900 | Christian Sci Pract visit | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| S9960 | Air ambulanc nonemerg fixed | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | ADM1001.005 | Ambulance and Medical Transport Services | | |
| S9961 | Air ambulan nonemerg rotary | Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a predetermination request if it is unclear if the service meets BCBSOK Medical Policy criteria. | ADM1001.005 | Ambulance and Medical Transport Services | | |
| S9970 | Health club membership yr | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| S9976 | Lodging per diem | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| S9977 | Meals per diem | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| S9981 | Med record copy admin | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| S9982 | Med record copy per page | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| S9986 | Not medically necessary svc | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| S9988 | Serv part of phase I trial | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| S9989 | Services outside US | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| S9990 | Services provided as part of | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| S9991 | Services provided as part of | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| S9992 | Transportation costs to and | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| S9994 | Lodging costs (e.g. hotel ch | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| S9996 | Meals for clinical trial par | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| S9999 | Sales tax | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| T1005 | Respite care service 15 min | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| T1006 | Family/Couple Counseling | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| T1009 | Child Sitting Services | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| T1010 | Meals when Receive Services | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| T1012 | Alcohol/Substance Abuse Skil | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| T1013 | Sign Lang/Oral Interpreter | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| T1014 | Telehealth transmit per min | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| T1018 | School-based IEP ser bundled | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| T1019 | Personal care ser per 15 min | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| T1029 | Dwelling lead investigation | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| T1032 | Sv doula brth wrk per 15 min | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | 10/1/2022 | |
| T1033 | Sv doula brth wrk per diem | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | 10/2/2022 | |
| T1505 | Elec med comp dev noc | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | | | | |
| T1999 | NOC retail items andsupplies | Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. | | | | |
| T2001 | N-et; patient attend/escort | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| T2002 | N-et; per diem | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| T2003 | N-et; encounter/trip | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| T2004 | N-et; commerc carrier pass | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| T2005 | N-et; stretcher van | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| T2007 | Non-emer transport wait time | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| T2012 | Habil ed waiver per diem | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |
| T2013 | Habil ed waiver per hour | Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. | | | | |