BlueCross BlueShield of Oklahoma

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

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

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

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

BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. All BCBSOK Medical Policies can be found at http://www.medicalpolicy.hcsc.net/medicalpolicy/index?corpEntCd=OK1

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

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

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

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

Code	Code Description	Code Group & Description	Medical Policy No.	Medical Policy Title	Effective Date	Ending Date
95919	QUAN PUPLMTRY PHY/QHP UNI/BI	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	MED205.034	Autonomic Nervous System (ANS) Testing	1/1/2023	
0783T	TC AURICULR NEUROSTIMULATION	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR702.019	Cranial Electrotherapy Stimulation and Auricular Electrostimulation	1/1/2023	
30469	RPR NSL VLV COLLAPSE W/RMDLG	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR706.001	Nasal and Sinus Surgery	1/1/2023	
43290	EGD FLX TRNSORL DPLMNT BALO	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR716.003	Bariatric Surgery	1/1/2023	
43291	EGD FLX TRNSORL RMVL BALO	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR716.003	Bariatric Surgery	1/1/2023	
36836	PRQ AV FSTL CRTJ UXTR 1 ACS	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.047	Percutaneous Arteriovenous Fistula	1/1/2023	
36837	PRQ AV FSTL CRT UXTR SEP ACS	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR701.047	Percutaneous Arteriovenous Fistula	1/1/2023	
0743T	B1 STR & FX RSK VRT FX ASSMT	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR705.033	Sacroiliac Joint Fixation/Fusion	1/1/2023	
0775T	ARTHRD SI JT PRQ IARTIC IMPL	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	ADM1001.032	N/A	1/1/2023	
Q4262	Dual layer impax, per sq cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	1/1/2023	
Q4263	Surgraft tl, per sq cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	1/1/2023	
Q4264	Cocoon membrane, per sq cm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy CPCP08, which is one of our Clinical Payment and Coding Policy (CPCP).	SUR704.011	Amniotic Membrane and Amniotic Fluid	1/1/2023	
92066	ORTHOP TRAING SUPVJ PHYS/QHP	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	OTH903.012	Orthoptics (Vergence/Accommodative Therapy), Visual Exercises or Training	1/1/2023	

69716	IMPL OI IMPLT SK TC ESP<100	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR714.003	Implantable Bone-Conduction and Bone-Anchored Hearing Aids	12/15/2022	
69719	RPLCM OI IMPLT SK TC ESP<100	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	SUR714.003	Implantable Bone-Conduction and Bone-Anchored Hearing Aids	12/15/2022	
69728	RMV NTR OI IMP SK TC>=100	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	RX504.003	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG])	1/1/2023	
69730	RPLC OI IMPLT SK TC ESP>=100	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	MED202.054	Biventricular Pacemakers (Cardiac Resynchronization Therapy) for the Treatment of Heart Failure	1/1/2023	
Q5125	Inj, releuko 1 mcg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	RX501.134	Oncologic Uses of White Blood Cell Colony Stimulating Factors		3/31/2023
00104	Anesth Electroshock	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR716.001 SUR716.011	Cosmetic and Reconstructive Procedures 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR716.001 SUR716.011	Cosmetic and Reconstructive Procedures 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR716.001 SUR716.011	Cosmetic and Reconstructive Procedures 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR716.001 SUR717.001 SUR706.009	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR716.001 SUR717.001 SUR706.009	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR716.001 SUR717.001 SUR706.009	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR716.001 SUR717.001 SUR706.009	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR716.001	Cosmetic and Reconstructive Procedures	_	_

11970		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK	SUR716.009 SUR716.001	Breast Implant, Removal and/or Insertion Cosmetic and Reconstructive Procedures		
	Rplcmt Tiss Xpndr Perm Implt	Medical Policy criteria.	SUR716.011	Reconstructive Breast Surgery	_	_
11980		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK	RXS01.063 SUR717.001 RXS01.007	Compounded Drug Products Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Hormone Replacement Therapies (HRT) Using Implanted Pellets for Women and Delayed Puberty		
	Implant Hormone Pellet(S)	Medical Policy criteria.	RXS01.076	Testosterone Replacement Therapies	_	_
11981		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK	RXS01.082 RXS01.007 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Treatment of Opioid Dependence Testosterone Replacement Therapies Hormone Replacement Therapies (HRT) Using Implanted Pellets for Women and Delayed Puberty		
	Insert Drug Implant Device	Medical Policy criteria.	RXS01.076		_	_
11982		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK	RXS01.082 RXS01.007 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Treatment of Opioid Dependence Testosterone Replacement Therapies Hormone Replacement Therapies (HRT) Using Implanted Pellets for Women and Delayed Puberty		
	Remove Drug Implant Device	Medical Policy criteria.	RXS01.076		_	_
11983		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK	RXS01.082 RXS01.007 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Treatment of Opioid Dependence Testosterone Replacement Therapies Hormone Replacement Therapies (HRT) Using Implanted Pellets for Women and Delayed Puberty		
	Remove/Insert Drug Implant	Medical Policy criteria.	RXS01.076		_	_
15758		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK				
	Free Fascial Flap Microvasc	Medical Policy criteria.	SUR701.024	Surgery for Lipedema and Lymphedema	_	_
15769		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK	SUR716.021	Reconstructive Breast Surgery Adipose-Derived Stem Cells in		
	Grfg Autol Soft Tiss Dir Exc	Medical Policy criteria.	SUR716.011	Autologous Fat Grafting to the Breast	1/15/2021	_
15771		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK	SUR716.021	Reconstructive Breast Surgery Adipose-Derived Stem Cells in		
	Grfg Autol Fat Lipo 50 Cc/<	Medical Policy criteria.	SUR716.011	Autologous Fat Grafting to the Breast	1/15/2021	_
15772		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK	SUR716.021	Reconstructive Breast Surgery Adipose-Derived Stem Cells in		
	Grfg Autol Fat Lipo Ea Addl	Medical Policy criteria.	SUR716.011	Autologous Fat Grafting to the Breast	1/15/2021	_
15775		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK	SUR716.001	Cosmetic and Reconstructive Procedures		
	Hair Trnspl 1-15 Punch Grfts	Medical Policy criteria.			_	_
15776		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK	SUR716.001	Cosmetic and Reconstructive Procedures		
	Hair Trnspl >15 Punch Grafts	Medical Policy criteria.			_	_
15780		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK	SUR716.001 THE801.030 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Cosmetic and Reconstructive Procedures Nonpharmacologic Treatment of Rosacea		
	Dermabrasion Total Face	Medical Policy criteria.	THE801.028	Acne Management	_	_
15781		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK	SUR716.001 THE801.030 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Cosmetic and Reconstructive Procedures Nonpharmacologic Treatment of Rosacea		
	Dermabrasion Segmental Face	Medical Policy criteria.	THE801.028	Acne Management	_	_
15782		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK	SUR716.001 THE801.030 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Cosmetic and Reconstructive Procedures Nonpharmacologic Treatment of Rosacea		
	Dermabrasion Other Than Face	Medical Policy criteria.	THE801.028	Acne Management	_	_
15783		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK	SUR716.001 THE801.030 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Cosmetic and Reconstructive Procedures Nonpharmacologic Treatment of Rosacea		
	Dermabrasion Suprfl Any Site	Medical Policy criteria.	THE801.028	Acne Management	_	_
15786		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK	SUR716.001 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Cosmetic and Reconstructive Procedures		
	Abrasion Lesion Single	Medical Policy criteria.	THE801.028	Acne Management	_	_
15787		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK	SUR716.001 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Cosmetic and Reconstructive Procedures		
	Abrasion Lesions Add-On	Medical Policy criteria.	THE801.028	Acne Management	_	_
15788		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK	SUR716.018 THE801.030 SUR717.001	Chemical Peels Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nonpharmacologic Treatment of Rosacea		
	Chemical Peel Face Epiderm	Medical Policy criteria.	THE801.028	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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR716.018 THE801.030 SUR717.001 THE801.028	Chemical Peels Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nonpharmacologic Treatment of Rosacea 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR716.018 THE801.030 SUR717.001 THE801.028	Chemical Peels Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nonpharmacologic Treatment of Rosacea 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR716.018 THE801.030 SUR717.001 THE801.028	Chemical Peels Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Nonpharmacologic Treatment of Rosacea 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR717.001 SUR716.004	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR717.001 SUR716.004	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR717.001 SUR716.004	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR717.001 SUR716.004	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services 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 SUR712.031 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Surgical Deactivation of Headache Trigger Sites 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR716.001 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services 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 SUR712.031 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Surgical Deactivation of Headache Trigger Sites 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR716.001 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services 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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR716.001 SUR717.001 SUR701.024	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR716.001 SUR701.024 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Cosmetic and Reconstructive Procedures 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR716.001 SUR701.024 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Cosmetic and Reconstructive Procedures 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR716.001 SUR701.024 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Cosmetic and Reconstructive Procedures 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR716.001 SUR701.024 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Cosmetic and Reconstructive Procedures 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR716.001 SUR701.024 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Cosmetic and Reconstructive Procedures 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR716.001 SUR701.024 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Cosmetic and Reconstructive Procedures 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR716.001 SUR701.024 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Cosmetic and Reconstructive Procedures 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR716.001 SUR716.017 SUR701.024 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Cosmetic and Reconstructive Procedures Surgical Treatment of Gynecomastia 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR716.001 SUR701.024	Cosmetic and Reconstructive Procedures 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR716.001 SUR701.024 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Cosmetic and Reconstructive Procedures 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR716.001 SUR701.024 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Cosmetic and Reconstructive Procedures 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR716.001 SUR701.024 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Cosmetic and Reconstructive Procedures 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR716.001 SUR701.024 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Cosmetic and Reconstructive Procedures 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	THE801.030 THE801.028 SUR704.008	Laser Treatment of Congenital Port Wine Stain (PWS), Hemangiomas, and Other External Vascular Malformations Nonpharmacologic Treatment of Rosacea 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	THE801.030 THE801.028 SUR704.008	Laser Treatment of Congenital Port Wine Stain (PWS), Hemangiomas, and Other External Vascular Malformations Nonpharmacologic Treatment of Rosacea 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	THE801.030 THE801.028 SUR704.008	Laser Treatment of Congenital Port Wine Stain (PWS), Hemangiomas, and Other External Vascular Malformations Nonpharmacologic Treatment of Rosacea 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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR716.001 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR716.015 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services 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 SUR717.001 SUR716.010	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Mastopexy 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 SUR717.001 SUR716.011 SUR716.012	Cosmetic and Reconstructive Procedures Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Reconstructive and Contralateral Mammaplasty 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR716.011 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR716.009 SUR716.011	Breast Implant, Removal and/or Insertion 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR716.009 SUR716.011	Breast Implant, Removal and/or Insertion 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR716.009 SUR716.011 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Breast Implant, Removal and/or Insertion 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR716.009 SUR716.011 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Breast Implant, Removal and/or Insertion 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR716.011 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR716.009 SUR716.011	Breast Implant, Removal and/or Insertion 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR716.021 SUR716.011 SUR701.031 SUR701.037	Laser Interstitial Tumor Therapy (LITT/ILT) and Laser Ablation Adipose-Derived Stem Cells in Autologous Fat Grafting to the Breast Handheld Radiofrequency Spectroscopy for Intraoperative Assessment of Surgical Margins During Breast-Conserving Surgery 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 Recommended Clinical Review (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 SUR712.036 SUR703.051 SUR712.041 SUR705.039	Bone Morphogenetic Protein Orthopedic Applications of Stem-Cell Therapy Use of i-Factor Peptide Enhanced Bone Graft During Spinal Surgery Lumbar Spinal Fusion 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 SUR712.036	Bone Morphogenetic Protein 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 SUR712.036	Lumbar Spinal Fusion 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 SUR705.044	Electrical Stimulation of the Spine as an Adjunct to Spinal Fusion Procedures 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 SUR705.044	Electrical Stimulation of the Spine as an Adjunct to Spinal Fusion Procedures 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	THE803.016 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 Recommended Clinical Review (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 SUR706.009 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR716.001 SUR706.009 SUR705.030 SUR705.010 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR716.001 SUR706.009 SUR705.030 SUR705.010 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR716.001 SUR706.009 SUR705.030 SUR705.010 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR716.001 SUR706.009 SUR705.030 SUR705.010 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 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 SUR705.030 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 SUR706.009 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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	Insert Spine Fixation Device	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 SUR712.036 SUR712.040	Cervical Spinal Fusion Lumbar Spinal Fusion Interspinous Fixation (Fusion) Devices	_	Moved to PA list	
22841	Insert Spine Fixation Device	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 SUR712.036	Lumbar Spinal Fusion Cervical Spinal Fusion	_	Moved to PA list	
22842	Insert Spine Fixation Device	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 SUR712.036	Lumbar Spinal Fusion Cervical Spinal Fusion	_	Moved to PA list	
22843	Insert Spine Fixation Device	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 SUR712.036	Lumbar Spinal Fusion Cervical Spinal Fusion	_	Moved to PA list	
22844	Insert Spine Fixation Device	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 SUR712.036	Lumbar Spinal Fusion Cervical Spinal Fusion	_	Moved to PA list	
22845	Insert Spine Fixation Device	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 SUR712.036	Lumbar Spinal Fusion Cervical Spinal Fusion	_	Moved to PA list	
22846	Insert Spine Fixation Device	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 SUR712.036	Lumbar Spinal Fusion Cervical Spinal Fusion	_	Moved to PA list	
22847	Insert Spine Fixation Device	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 SUR712.036	Lumbar Spinal Fusion Cervical Spinal Fusion	_	Moved to PA list	
22848	Insert Pelv Fixation Device	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	
22853	Insj Biomechanical Device	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 SUR712.036 SUR712.040	Cervical Spinal Fusion Lumbar Spinal Fusion Interspinous Fixation (Fusion) Devices	_	Moved to PA list	
22854	Insj Biomechanical Device	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 SUR712.036 SUR712.040	Cervical Spinal Fusion Lumbar Spinal Fusion Interspinous Fixation (Fusion) Devices	_	Moved to PA list	
22856	Cerv Artific Diskectomy	Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website.	SUR712.028	Artificial Intervertebral Disc	_	Moved to PA list	
22857	Lumbar Artif Diskectomy	Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website.	SUR712.028	Artificial Intervertebral Disc	_	Moved to PA list	
22858	Second Level Cer Diskectomy	Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website.	SUR712.028	Artificial Intervertebral Disc	_	Moved to PA list	
22859	Insj Biomechanical Device	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 SUR712.036 SUR712.040	Cervical Spinal Fusion Lumbar Spinal Fusion Interspinous Fixation (Fusion) Devices	_	Moved to PA list	
22862	Revise Lumbar Artif Disc	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	
22865	Remove Lumb Artif Disc	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	
22867	Insj Stablj Dev W/Dcmprn	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	SUR712.029	Interspinous Distraction (Spacers) and Interlaminar Stabilization Devices	1/1/2023	_	
22867	Insj Stablj Dev W/Dcmprn	Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website.	SUR712.029	Interspinous Distraction (Spacers) and Interlaminar Stabilization Devices	_	Moved to PA list	
22867	Insj Stablj Dev W/Dcmprn	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (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	
22868	Insj Stablj Dev W/Dcmprn	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	SUR712.029	Interspinous Distraction (Spacers) and Interlaminar Stabilization Devices	1/1/2023	_	

22868	Insj Stablj Dev W/Dcmprn	Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website.	SUR712.029	Interspinous Distraction (Spacers) and Interlaminar Stabilization Devices	_	Moved to PA list	
22868	Insj Stablj Dev W/Dcmprn	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (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
22869	Insj Stablj Dev W/O Dcmprn	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	SUR712.029	Interspinous Distraction (Spacers) and Interlaminar Stabilization Devices	1/1/2023	_	
22869	Insj Stablj Dev W/O Dcmprn	Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website.	SUR712.029	Interspinous Distraction (Spacers) and Interlaminar Stabilization Devices	_	Moved to PA list	
22869	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 Recommended Clinical Review (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
22870	Insj Stablj Dev W/O Dcmprn	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	SUR712.029	Interspinous Distraction (Spacers) and Interlaminar Stabilization Devices	1/1/2023	_	
22870	Insj Stablj Dev W/O Dcmprn	Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the BCBSOK website.	SUR712.029	Interspinous Distraction (Spacers) and Interlaminar 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR705.020 SUR705.035	Autologous Chondrocyte Implantation (ACI) for Focal Articular Cartilage Lesions 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 Recommended Clinical Review (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	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR705.034	Meniscal Allografts and 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR705.024 SUR705.029 SUR705.041	Unicondylar Interpositional Spacer as a Treatment of Unicompartmental Arthritis of the Knee Surgical Treatment of Femoroacetabular Impingement (FAI) Thermal Capsulorrhaphy as a Treatment of Joint Instability	_	_	
30120	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 THE801.030	Nonpharmacologic Treatment of Rosacea Nasal and Sinus Surgery	_	_	
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 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services 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 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services 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 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services 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 SUR717.001	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services 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 SUR717.001		Gender Assignment Surgery and Gender Reassignment Surgery with Related Services 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 SUR717.001		Gender Assignment Surgery and Gender Reassignment Surgery with Related Services 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	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.	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 Recommended Clinical Review (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 Recommended Clinical Review (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	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.	SUR706.001 SUR706.019		Nasal and Sinus Surgery Balloon Ostial Dilation for Treatment of Chronic and Recurrent Acute Rhinosinusitis	_	_	
31572	Largsc W/Laser Dstrj Les	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR703.027 SUR707.026 SUR701.009	Stem-Cell Therapy for the Treatment of Damaged Myocardium Due to Ischemia Cardiac Restoration and Remodeling Procedures 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR703.042 SUR703.030 SUR703.033 SUR703.037 SUR703.038 SUR703.034 SUR703.046 SUR703.050 SUR703.041 SUR703.047 SUR703.036 SUR703.029 SUR703.032 SUR703.031 SUR703.043 SUR703.045 SUR703.035 SUR703.040 SUR703.002 THE801.024 SUR703.044 SUR703.039	Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML) Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Adoptive Immunotherapy	_	_
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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	RAD601.047 SUR701.015 THE801.022	Radioembolization for Primary and Metastatic Tumors of the Liver Therapeutic Embolization and Vessel Occlusion to Treat Pelvic Conditions 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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	BI Donor Search Management	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR703.042 SUR703.033 SUR703.030 SUR703.037 SUR703.038 SUR703.034 SUR703.046 SUR703.050 SUR703.041 SUR703.036 SUR703.047 SUR703.029 SUR703.032 SUR703.031 SUR703.043 SUR703.045 SUR703.035 SUR703.040 SUR703.002 SUR703.044 SUR703.039	Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML) Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for	_	_

38205					Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML) Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL)		
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			SUR703.029			
			SUR703.032			
			SUR703.031			
			SUR703.043			
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK	SUR703.045			
			SUR703.035			
			SUR703.040			
			SUR703.002			
			SUR703.044			
	Harvest Allogeneic Stem Cell	Medical Policy criteria.	SUR703.039		Hematopoietic Cell Transplantation for	_ _
38206					Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML) Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL)		
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			SUR703.043			
			SUR703.045			
			SUR703.035			
		Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the	SUR703.040			
			SUR703.002			
			SUR703.044			
	Harvest Auto Stem Cells	BCBSOK website.	SUR703.039		Hematopoietic Cell Transplantation for	_ _
38207					Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML) Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL)		
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			SUR703.029			
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			SUR703.031			
			SUR703.043			
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK	SUR703.045			
			SUR703.035			
			SUR703.040			
			SUR703.002			
			SUR703.044			
	Cryopreserve Stem Cells	Medical Policy criteria.	SUR703.039		Hematopoietic Cell Transplantation for	_ _

38208					Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML) Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for		
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			SUR703.033		Hematopoietic Cell Transplantation		
			SUR703.030		(HCT) or Additional Infusion Following		
			SUR703.037		Preparative Regimens (General Donor		
			SUR703.038		and Recipient Information)		
			SUR703.034		Hematopoietic Cell Transplantation for		
			SUR703.046		Miscellaneous Solid Tumors in Adults		
			SUR703.050		Hematopoietic Cell Transplantation for		
			SUR703.041		Malignant Astrocytomas and Gliomas		
			SUR703.036		Hematopoietic Cell Transplantation for		
			SUR703.047		Breast Cancer		
			SUR703.029		Hematopoietic Cell Transplantation for		
			SUR703.032		Solid Tumors in Children		
			SUR703.031		Hematopoietic Cell Transplantation for		
			SUR703.043		Genetic Diseases and Acquired Anemias		
		Medical Policy Criteria: Procedure/service reviewed to	SUR703.045		Hematopoietic Cell Transplantation for		
		ensure each service meets BCBSOK Medical Policy	SUR703.035		Autoimmune Diseases		
		criteria. BCBSOK recommends submitting a	SUR703.040		Hematopoietic Cell Transplantation as a		
		Recommended Clinical Review (Predetermination)	SUR703.002		Treatment of Acute Lymphoblastic		
		request if it is unclear if the service meets BCBSOK	SUR703.044		Leukemia (ALL)		
	Thaw Preserved Stem Cells	Medical Policy criteria.	SUR703.039		Hematopoietic Cell Transplantation for	_	_
38209					Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML) Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for		
			SUR703.042		Hodgkin Lymphoma (HL)		
			SUR703.033		Hematopoietic Cell Transplantation		
			SUR703.030		(HCT) or Additional Infusion Following		
			SUR703.037		Preparative Regimens (General Donor		
			SUR703.038		and Recipient Information)		
			SUR703.034		Hematopoietic Cell Transplantation for		
			SUR703.046		Miscellaneous Solid Tumors in Adults		
			SUR703.050		Hematopoietic Cell Transplantation for		
			SUR703.041		Malignant Astrocytomas and Gliomas		
			SUR703.036		Hematopoietic Cell Transplantation for		
			SUR703.047		Breast Cancer		
			SUR703.029		Hematopoietic Cell Transplantation for		
			SUR703.032		Solid Tumors in Children		
			SUR703.031		Hematopoietic Cell Transplantation for		
			SUR703.043		Genetic Diseases and Acquired Anemias		
		Medical Policy Criteria: Procedure/service reviewed to	SUR703.045		Hematopoietic Cell Transplantation for		
		ensure each service meets BCBSOK Medical Policy	SUR703.035		Autoimmune Diseases		
		criteria. BCBSOK recommends submitting a	SUR703.040		Hematopoietic Cell Transplantation as a		
		Recommended Clinical Review (Predetermination)	SUR703.002		Treatment of Acute Lymphoblastic		
		request if it is unclear if the service meets BCBSOK	SUR703.044		Leukemia (ALL)		
	Wash Harvest Stem Cells	Medical Policy criteria.	SUR703.039		Hematopoietic Cell Transplantation for	_	_
38210					Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML) Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for		
			SUR703.042		Hodgkin Lymphoma (HL)		
			SUR703.033		Hematopoietic Cell Transplantation		
			SUR703.030		(HCT) or Additional Infusion Following		
			SUR703.037		Preparative Regimens (General Donor		
			SUR703.038		and Recipient Information)		
			SUR703.034		Hematopoietic Cell Transplantation for		
			SUR703.046		Miscellaneous Solid Tumors in Adults		
			SUR703.050		Hematopoietic Cell Transplantation for		
			SUR703.041		Malignant Astrocytomas and Gliomas		
			SUR703.036		Hematopoietic Cell Transplantation for		
			SUR703.047		Breast Cancer		
			SUR703.029		Hematopoietic Cell Transplantation for		
			SUR703.032		Solid Tumors in Children		
			SUR703.031		Hematopoietic Cell Transplantation for		
			SUR703.043		Genetic Diseases and Acquired Anemias		
		Medical Policy Criteria: Procedure/service reviewed to	SUR703.045		Hematopoietic Cell Transplantation for		
		ensure each service meets BCBSOK Medical Policy	SUR703.035		Autoimmune Diseases		
		criteria. BCBSOK recommends submitting a	SUR703.040		Hematopoietic Cell Transplantation as a		
		Recommended Clinical Review (Predetermination)	SUR703.002		Treatment of Acute Lymphoblastic		
		request if it is unclear if the service meets BCBSOK	SUR703.044		Leukemia (ALL)		
	T-Cell Depletion Of Harvest	Medical Policy criteria.	SUR703.039		Hematopoietic Cell Transplantation for	_	_

38211					Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML) Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for		
			SUR703.042		Hodgkin Lymphoma (HL)		
			SUR703.033		Hematopoietic Cell Transplantation		
			SUR703.030		(HCT) or Additional Infusion Following		
			SUR703.037		Preparative Regimens (General Donor		
			SUR703.038		and Recipient Information)		
			SUR703.034		Hematopoietic Cell Transplantation for		
			SUR703.046		Miscellaneous Solid Tumors in Adults		
			SUR703.050		Hematopoietic Cell Transplantation for		
			SUR703.041		Malignant Astrocytomas and Gliomas		
			SUR703.036		Hematopoietic Cell Transplantation for		
			SUR703.047		Breast Cancer		
			SUR703.029		Hematopoietic Cell Transplantation for		
			SUR703.032		Solid Tumors in Children		
			SUR703.031		Hematopoietic Cell Transplantation for		
			SUR703.043		Genetic Diseases and Acquired Anemias		
		Medical Policy Criteria: Procedure/service reviewed to	SUR703.045		Hematopoietic Cell Transplantation for		
		ensure each service meets BCBSOK Medical Policy	SUR703.035		Autoimmune Diseases		
		criteria. BCBSOK recommends submitting a	SUR703.040		Hematopoietic Cell Transplantation as a		
		Recommended Clinical Review (Predetermination)	SUR703.002		Treatment of Acute Lymphoblastic		
		request if it is unclear if the service meets BCBSOK	SUR703.044		Leukemia (ALL)		
	Tumor Cell Deplete Of Harvst	Medical Policy criteria.	SUR703.039		Hematopoietic Cell Transplantation for	_	_
38212					Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML) Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for		
			SUR703.042		Hodgkin Lymphoma (HL)		
			SUR703.033		Hematopoietic Cell Transplantation		
			SUR703.030		(HCT) or Additional Infusion Following		
			SUR703.037		Preparative Regimens (General Donor		
			SUR703.038		and Recipient Information)		
			SUR703.034		Hematopoietic Cell Transplantation for		
			SUR703.046		Miscellaneous Solid Tumors in Adults		
			SUR703.050		Hematopoietic Cell Transplantation for		
			SUR703.041		Malignant Astrocytomas and Gliomas		
			SUR703.036		Hematopoietic Cell Transplantation for		
			SUR703.047		Breast Cancer		
			SUR703.029		Hematopoietic Cell Transplantation for		
			SUR703.032		Solid Tumors in Children		
			SUR703.031		Hematopoietic Cell Transplantation for		
			SUR703.043		Genetic Diseases and Acquired Anemias		
		Medical Policy Criteria: Procedure/service reviewed to	SUR703.045		Hematopoietic Cell Transplantation for		
		ensure each service meets BCBSOK Medical Policy	SUR703.035		Autoimmune Diseases		
		criteria. BCBSOK recommends submitting a	SUR703.040		Hematopoietic Cell Transplantation as a		
		Recommended Clinical Review (Predetermination)	SUR703.002		Treatment of Acute Lymphoblastic		
		request if it is unclear if the service meets BCBSOK	SUR703.044		Leukemia (ALL)		
	Rbc Depletion Of Harvest	Medical Policy criteria.	SUR703.039		Hematopoietic Cell Transplantation for	_	_
38213					Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML) Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for		
			SUR703.042		Hodgkin Lymphoma (HL)		
			SUR703.033		Hematopoietic Cell Transplantation		
			SUR703.030		(HCT) or Additional Infusion Following		
			SUR703.037		Preparative Regimens (General Donor		
			SUR703.038		and Recipient Information)		
			SUR703.034		Hematopoietic Cell Transplantation for		
			SUR703.046		Miscellaneous Solid Tumors in Adults		
			SUR703.050		Hematopoietic Cell Transplantation for		
			SUR703.041		Malignant Astrocytomas and Gliomas		
			SUR703.036		Hematopoietic Cell Transplantation for		
			SUR703.047		Breast Cancer		
			SUR703.029		Hematopoietic Cell Transplantation for		
			SUR703.032		Solid Tumors in Children		
			SUR703.031		Hematopoietic Cell Transplantation for		
			SUR703.043		Genetic Diseases and Acquired Anemias		
		Medical Policy Criteria: Procedure/service reviewed to	SUR703.045		Hematopoietic Cell Transplantation for		
		ensure each service meets BCBSOK Medical Policy	SUR703.035		Autoimmune Diseases		
		criteria. BCBSOK recommends submitting a	SUR703.040		Hematopoietic Cell Transplantation as a		
		Recommended Clinical Review (Predetermination)	SUR703.002		Treatment of Acute Lymphoblastic		
		request if it is unclear if the service meets BCBSOK	SUR703.044		Leukemia (ALL)		
	Platelet Deplete Of Harvest	Medical Policy criteria.	SUR703.039		Hematopoietic Cell Transplantation for	_	_

38214					Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML) Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL)		
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			SUR703.036			
			SUR703.047			
			SUR703.029			
			SUR703.032			
			SUR703.031			
			SUR703.043			
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK	SUR703.045			
			SUR703.035			
			SUR703.040			
			SUR703.002			
			SUR703.044			
	Volume Deplete Of Harvest	Medical Policy criteria.	SUR703.039		Hematopoietic Cell Transplantation for	_ _
38215					Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML) Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL)		
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			SUR703.046			
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			SUR703.036			
			SUR703.047			
			SUR703.029			
			SUR703.032			
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			SUR703.043			
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK	SUR703.045			
			SUR703.035			
			SUR703.040			
			SUR703.002			
			SUR703.044			
	Harvest Stem Cell Concentrte	Medical Policy criteria.	SUR703.039		Hematopoietic Cell Transplantation for	_ _
38230					Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML) Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL)		
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			SUR703.034			
			SUR703.046			
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			SUR703.036			
			SUR703.047			
			SUR703.029			
			SUR703.032			
			SUR703.031			
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			SUR703.045			
			SUR703.035			
		Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the	SUR703.040			
			SUR703.002			
			SUR703.044			
	Bone Marrow Harvest Allogen	BCBSOK website.	SUR703.039		Hematopoietic Cell Transplantation for	_ _

38232					Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML) Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL)		
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		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK	SUR703.045			
			SUR703.035			
			SUR703.040			
			SUR703.002			
			SUR703.044			
	Bone Marrow Harvest Autolog	Medical Policy criteria.	SUR703.039		Hematopoietic Cell Transplantation for	_ _
38240					Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML) Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL)		
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			SUR703.046			
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		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK	SUR703.045			
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			SUR703.040			
			SUR703.002			
			SUR703.044			
	Transplt Allo Hct/Donor	Medical Policy criteria.	SUR703.039		Hematopoietic Cell Transplantation for	_ _
38241					Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML) Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Waldenstrom Macroglobulinemia Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL)		
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		Medical Policy Criteria: Procedure/service may require prior authorization. Refer to prior authorization resources available on the provider section of the	SUR703.040			
			SUR703.002			
			SUR703.044			
	Transplt Autol Hct/Donor	BCBSOK website.	SUR703.039		Hematopoietic Cell Transplantation for	_ _

38242	Transplt Allo Lymphocytes	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR703.042 SUR703.033 SUR703.030 SUR703.037 SUR703.038 SUR703.034 SUR703.046 SUR703.050 SUR703.041 SUR703.036 SUR703.047 SUR703.029 SUR703.032 SUR703.031 SUR703.043 SUR703.045 SUR703.035 SUR703.040 SUR703.002 SUR703.044 SUR703.039	Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML) Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for	_	_
38243	Transplj Hematopoietic Boost	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR703.042 SUR703.033 SUR703.030 SUR703.037 SUR703.038 SUR703.034 SUR703.046 SUR703.050 SUR703.041 SUR703.036 SUR703.047 SUR703.029 SUR703.032 SUR703.031 SUR703.043 SUR703.045 SUR703.035 SUR703.040 SUR703.002 SUR703.044 SUR703.039	Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML) Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for	_	_
38308	Incision Of Lymph Channels	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	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 Recommended Clinical Review (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 Recommended Clinical Review (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 SUR701.021	Radiofrequency Ablation (RFA) of Solid Tumors, Excluding Liver 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	RX501.019 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	RX501.019 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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	RX501.019 SUR716.003 MED201.016	Bariatric Surgery 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR709.029 SUR701.038		Microwave Tumor Ablation 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR703.013 SUR703.008 SUR703.007		Kidney Transplant Pancreas and Related Organ Tissue Transplantation 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR701.018 SUR701.021		Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR701.018 SUR701.021		Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors 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 Recommended Clinical Review (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	_	_
50593	Perc Cryo Ablate Renal Tum	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	RXS01.019	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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	RXS01.073 MED201.030	Clostridial Collagenase for Fibroproliferative Disorders 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	RXS01.073 MED201.030	Clostridial Collagenase for Fibroproliferative Disorders 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	RXS01.073 MED201.030	Clostridial Collagenase for Fibroproliferative Disorders 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR717.001 MED201.030	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR717.001 MED201.030	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR717.001 MED201.030	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR717.001 MED201.030		Gender Assignment Surgery and Gender Reassignment Surgery with Related Services 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR717.001 MED201.030		Gender Assignment Surgery and Gender Reassignment Surgery with Related Services 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR717.001 MED201.030		Gender Assignment Surgery and Gender Reassignment Surgery with Related Services 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR717.001 MED201.030		Gender Assignment Surgery and Gender Reassignment Surgery with Related Services 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR717.001 MED201.030		Gender Assignment Surgery and Gender Reassignment Surgery with Related Services 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR717.001 MED201.030		Gender Assignment Surgery and Gender Reassignment Surgery with Related Services 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR717.001 MED201.030		Gender Assignment Surgery and Gender Reassignment Surgery with Related Services 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR716.001 SUR717.001		Gender Assignment Surgery and Gender Reassignment Surgery with Related Services 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	#N/A		#N/A	_	_
55880	Ablti Mal Prst8 Tiss Hifu	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR717.001 MED201.030		Gender Assignment Surgery and Gender Reassignment Surgery with Related Services 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR717.001 MED201.030	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services 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 Recommended Clinical Review (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 Ablt Uterine Fibroids	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 MED202.064	Diagnosis and Treatment of Chronic Cerebrospinal Venous Insufficiency in Multiple Sclerosis 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 SUR712.025	Responsive Neurostimulation (RNS) for the Treatment of Refractory Focal Epilepsy 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 SUR712.025 SUR712.039	Auditory Brainstem Implant Deep Brain Stimulation (DBS) 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 SUR712.025 SUR712.039	Auditory Brainstem Implant Deep Brain Stimulation (DBS) 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 SUR712.025	Auditory Brainstem Implant 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 SUR712.025	Auditory Brainstem Implant 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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR712.021 SUR712.025 SUR712.039	Vagus Nerve Stimulation (VNS) Responsive Neurostimulation (RNS) for the Treatment of Refractory Focal Epilepsy 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 Recommended Clinical Review (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 SUR712.037	Automated Percutaneous Discectomy and Percutaneous Endoscopic Discectomy 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 SUR712.004	Automated Percutaneous Discectomy and Percutaneous Endoscopic Discectomy 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR712.004 SUR712.037	Automated Percutaneous Discectomy and Percutaneous Endoscopic Discectomy 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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR712.021 SUR705.010	Vagus Nerve Stimulation (VNS) 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR705.010 MED205.032	Temporomandibular Joint (TMJ) Disorders (TMJD) 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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR712.033 SUR706.009 SUR712.021	Occipital Nerve Stimulation Sleep Related Breathing Disorders: Surgical Management 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR710.018 SUR709.031 MED205.032	Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS) Gastric Electrical Stimulation (GES) 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	RXS01.019	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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	OTH903.044 OTH903.020 OTH903.027 OTH903.024 OTH903.026 OTH903.041	Faricimab-svoa Intravitreal Angiogenesis Inhibitors for Choroidal Vascular Conditions Intravitreal Angiogenesis Inhibitors for Retinal Vascular Disorders Intravitreal, Punctum, and Intracameral Implants Ocriplasmin for Symptomatic Vitreomacular Adhesion 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 Recommended Clinical Review (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 Recommended Clinical Review (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 SUR716.004	Surgical Deactivation of Headache Trigger Sites 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR701.027 RAD601.047 SUR701.015 THE801.022		Intracranial Stenting or Angioplasty, including Endovascular Procedures Radioembolization for Primary and Metastatic Tumors of the Liver Therapeutic Embolization and Vessel Occlusion to Treat Pelvic Conditions 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	RAD601.046 SUR705.010		Dynamic Spinal Visualization and Vertebral Motion Analysis 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	RAD601.046 SUR705.010		Dynamic Spinal Visualization and Vertebral Motion Analysis 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR709.029 SUR701.038 SUR701.021 SUR701.018 SUR701.032	Microwave Tumor Ablation Cryosurgical Ablation of Primary or Metastatic Liver Tumors Radiofrequency Ablation (RFA) of Solid Tumors, Excluding Liver Radiofrequency Ablation (RFA) of Primary or Metastatic Liver Tumors 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR701.032 SUR701.018 SUR701.021	Cryosurgical Ablation of Primary or Metastatic Liver Tumors Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR701.032 SUR701.018 SUR701.021	Cryosurgical Ablation of Primary or Metastatic Liver Tumors Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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	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.	SUR703.042 SUR703.033 SUR703.030 SUR703.037 SUR703.038 SUR703.034 SUR703.046 SUR703.050 SUR703.041 SUR703.036 SUR703.047 SUR703.029 SUR703.032 SUR703.031 SUR703.043 SUR703.045 SUR703.035 SUR703.040 SUR703.002 SUR703.044 SUR703.039	Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML) Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for	_	Moved to PA list
81266	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.	SUR703.042 SUR703.033 SUR703.030 SUR703.037 SUR703.038 SUR703.034 SUR703.046 SUR703.050 SUR703.041 SUR703.036 SUR703.047 SUR703.029 SUR703.032 SUR703.031 SUR703.043 SUR703.045 SUR703.035 SUR703.040 SUR703.002 SUR703.044 SUR703.039	Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML) Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for	_	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 MED207.008	Novel Biomarkers in Risk Assessment and Management of Cardiovascular Disease 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	MED207.154 MED207.088 MED207.136 MED207.153 MED207.128 MED207.159 OB401.018	Drug Testing in Pain Management and Substance Use Disorder Monitoring Intracellular Micronutrient Analysis Measurement of Long Chain Omega-3 Fatty Acids in Red Blood Cell Membranes as a Cardiac Risk Factor Measurement of Serum Antibodies to Selected Biologic Agents Salivary Hormone Testing Serum Biomarker Panel Testing for Systemic Lupus Erythematosus and Other Connective Tissue Diseases 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR703.042 SUR703.033 SUR703.030 SUR703.037 SUR703.038 SUR703.034 SUR703.046 SUR703.050 SUR703.041 SUR703.036 SUR703.047 SUR703.029 SUR703.032 SUR703.031 SUR703.043 SUR703.045 SUR703.035 SUR703.040 SUR703.002 SUR703.044 SUR703.039	Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML) Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL) Hematopoietic Cell Transplantation for	_	_
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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	PSY301.018 PSY301.017 PSY301.019 PSY301.016 PSY301.007 PSY301.011 MED205.022		Biofeedback as a Treatment of Chronic Pain Biofeedback as a Treatment of Fecal Incontinence or Constipation Biofeedback as a Treatment of Headache Biofeedback as a Treatment of Urinary Incontinence Biofeedback for Miscellaneous Indications Neurofeedback 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	PSY301.018 PSY301.017 PSY301.019 PSY301.016 PSY301.007 PSY301.011 MED205.022		Biofeedback as a Treatment of Chronic Pain Biofeedback as a Treatment of Fecal Incontinence or Constipation Biofeedback as a Treatment of Headache Biofeedback as a Treatment of Urinary Incontinence Biofeedback for Miscellaneous Indications Neurofeedback Treatment of Tinnitus	_	_	
90880	Hypnotherapy	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	PSY301.018 PSY301.017 PSY301.019 PSY301.016 PSY301.007 PSY301.011 MED205.022		Biofeedback as a Treatment of Chronic Pain Biofeedback as a Treatment of Fecal Incontinence or Constipation Biofeedback as a Treatment of Headache Biofeedback as a Treatment of Urinary Incontinence Biofeedback for Miscellaneous Indications Neurofeedback 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	PSY301.017 PSY301.016		Biofeedback as a Treatment of Fecal Incontinence or Constipation 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	PSY301.017 PSY301.016		Biofeedback as a Treatment of Fecal Incontinence or Constipation 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR707.003 MED202.054		Implantable Cardioverter Defibrillators 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR707.003 MED202.054		Implantable Cardioverter Defibrillators 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR707.003 MED202.054		Implantable Cardioverter Defibrillators 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	PSY301.014 MED206.001	Allergy Management 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 MED206.001	Allergy Management 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 MED206.001	Allergy Management 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	MED204.005 MED201.049	Diagnosis and Medical Management of Sleep Related Breathing Disorders 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	MED204.005 MED201.049	Diagnosis and Medical Management of Sleep Related Breathing Disorders 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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	MED204.005 MED201.049	Polysomnography for Non-Respiratory Sleep Disorders 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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	MED204.005 MED201.049	Polysomnography for Non-Respiratory Sleep Disorders 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	MED204.005 MED201.049	Diagnosis and Medical Management of Obstructive Sleep Apnea Syndrome 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	MED204.005 MED201.049	Diagnosis and Medical Management of Obstructive Sleep Apnea Syndrome 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	MED205.011 MED205.009	Topographic Brain Mapping (Quantitative Electroencephalography) 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	MED205.011 MED205.009	Topographic Brain Mapping (Quantitative Electroencephalography) 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	RAD601.038 PSY301.014	Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI) 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	RAD601.038 PSY301.014	Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI) 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	RAD601.038 PSY301.014	Magnetoencephalography (MEG) and Magnetic Source Imaging (MSI) 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR710.018 SUR712.025 MED205.032 SUR712.039 SUR712.009	Sacral Nerve Neuromodulation/Stimulation Deep Brain Stimulation (DBS) Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS) Spinal Cord Stimulation (SCS) and Dorsal Root Ganglion (DRG) Stimulation 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	MED205.036 SUR712.039 SUR710.018 SUR712.009 SUR712.021	Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS) Responsive Neurostimulation (RNS) for the Treatment of Refractory Focal Epilepsy Sacral Nerve Neuromodulation/Stimulation Spinal Cord Stimulation (SCS) and Dorsal Root Ganglion (DRG) Stimulation 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	MED205.036 SUR712.009	Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS) 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	THE803.009 MED205.006	Gait Analysis 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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	THE803.009 MED205.006	Gait Analysis Surface Scanning 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	THE801.033 THE801.028	Phototherapy for Dermatologic Conditions 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	THE803.008 THE803.010 SUR705.010	Non Covered Physical Therapy Services Physical Therapy (PT) and Occupational Therapy (OT) Services 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	PSY301.014 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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).	RXS01.034 RXS01.101	Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions 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 Recommended Clinical Review (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 SUR703.048	Stem Cell Therapy for Peripheral Arterial Disease (PAD) 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 SUR703.048	Stem Cell Therapy for Peripheral Arterial Disease (PAD) 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 SUR703.048	Stem Cell Therapy for Peripheral Arterial Disease (PAD) 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	#N/A	#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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	#N/A	#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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	#N/A	#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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	#N/A	#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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	#N/A	#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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	#N/A	#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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	RXS01.034 RXS01.101	Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR703.006 SUR703.010	Lung and Lobar Lung Transplant 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR703.006 SUR703.010	Lung and Lobar Lung Transplant 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR703.006 SUR703.010	Lung and Lobar Lung Transplant 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Ablt W/Img	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	MED201.045 MED205.022	Low-Level and High-Power Laser Therapy 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Implt/j/Rplcmt Isdns Ptn	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	THE801.003 PSY301.014	Hyperbaric Oxygen (HBO2) Therapy 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 PSY301.014	Hyperbaric Oxygen (HBO2) Therapy 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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR710.018 SUR701.039 SUR712.025 SUR709.031 SUR712.021 SUR712.039 SUR712.033 SUR712.009	Sacral Nerve Neuromodulation/Stimulation Gastric Electrical Stimulation (GES) Deep Brain Stimulation (DBS) Vagus Nerve Stimulation (VNS) Spinal Cord Stimulation (SCS) and Dorsal Root Ganglion (DRG) Stimulation Occipital Nerve Stimulation Responsive Neurostimulation (RNS) for the Treatment of Refractory Focal Epilepsy 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR705.021 SUR705.024	Total Ankle Replacement (TAR) 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	MED205.036 SUR712.009	Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS) 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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	MED205.036 SUR712.009	Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS) 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	MED205.036 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	MED205.036 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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	MED205.036 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	MED205.036 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR701.028 SUR701.027 SUR701.041	Endovascular Therapies for Extracranial Vertebral Artery Disease Extracranial Carotid Angioplasty or Stenting 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 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)	_	_		
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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 AIM	Annulus Closure After Discectomy 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	#N/A	#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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers 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 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	MED202.060 MED202.073	Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 DME101.037	Pelvic Floor Stimulation (PFS) as a Treatment of Urinary or Fecal Incontinence 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 Recommended Clinical Review (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 SUR710.018	Sacral Nerve Neuromodulation/Stimulation 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	PSY301.019 PSY301.018 PSY301.016 SUR705.010 PSY301.007 PSY301.017	Biofeedback for Miscellaneous Indications Temporomandibular Joint (TMJ) Disorders (TMJD) Biofeedback as a Treatment of Chronic Pain Biofeedback as a Treatment of Headache Biofeedback as a Treatment of Fecal Incontinence or Constipation 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 Recommended Clinical Review (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 SUR705.044	Electrical Stimulation of the Spine as an Adjunct to Spinal Fusion Procedures 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	RXS04.015 MED201.011	Levodopa-Carbidopa Enteral Suspension (e.g. Duopa) for The Treatment of Parkinson Disease. 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 DME101.041	Pneumatic Traction and Spinal Unloading Devices 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 DME101.041	Pneumatic Traction and Spinal Unloading Devices 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	DME101.010 DME101.034	Wheelchairs and Accessories 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	DME101.010 DME101.034	Wheelchairs and Accessories 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 SUR705.010	Mechanical Stretching Devices 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 SUR705.010	Mechanical Stretching Devices 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 SUR705.010	Mechanical Stretching Devices 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	DME103.009 DME103.001	Mechanical Stretching Devices 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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	DME103.009 DME103.001	Mechanical Stretching Devices 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	DME103.009 DME103.001	Mechanical Stretching Devices 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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	DME103.009 DME103.001	Mechanical Stretching Devices 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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	DME103.009 DME103.001	Mechanical Stretching Devices 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	DME103.001 DME103.009	Orthotics 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	DME103.009 DME103.001	Mechanical Stretching Devices 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	DME103.001 DME103.009	Orthotics 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	DME103.009 DME103.001	Mechanical Stretching Devices 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	DME103.009 DME103.001	Mechanical Stretching Devices 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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	DME103.001 DME103.009	Orthotics 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	DME101.010 DME101.034	Wheelchairs and Accessories 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	DME101.010 DME101.034	Wheelchairs and Accessories 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	DME101.010 DME101.034	Wheelchairs and Accessories 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	PSY301.014 THE803.010	Physical Therapy (PT) and Occupational Therapy (OT) Services 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	PSY301.014 THE803.010	Physical Therapy (PT) and Occupational Therapy (OT) Services 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	PSY301.014 THE803.014	Speech-Language Therapy (SLT) 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	PSY301.014 THE803.010	Physical Therapy (PT) and Occupational Therapy (OT) Services 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	PSY301.014 THE803.010	Physical Therapy (PT) and Occupational Therapy (OT) Services 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	PSY301.014 THE803.010	Physical Therapy (PT) and Occupational Therapy (OT) Services 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	PSY301.014 THE803.010	Physical Therapy (PT) and Occupational Therapy (OT) Services 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	PSY301.014 THE803.014	Speech-Language Therapy (SLT) 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	#N/A	#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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	#N/A	#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	#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	#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	#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	#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	#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	#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 MED201.027		Electrostimulation and Electromagnetic Therapy for Treating Wounds 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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).	RXS01.034	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).	RXS01.034	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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	RXS01.034	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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	RXS01.082 RXS01.007 RXS01.076	Testosterone Replacement Therapies Treatment of Opioid Dependence 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	RXS01.082 RXS01.007 RXS01.076	Testosterone Replacement Therapies Treatment of Opioid Dependence 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	RXS01.007 RXS01.076 RXS01.082	Hormone Replacement Therapies (HRT) Using Implanted Pellets for Women and Delayed Puberty Testosterone Replacement Therapies 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	RXS01.105	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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	RXS01.105	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 RX501.096	Specialty Medication Administration Site of Care 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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	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)	_	_	
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 RX501.067	Specialty Medication Administration Site of Care 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 RX501.067	Specialty Medication Administration Site of Care 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 RX501.102	Specialty Medication Administration Site of Care 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 RX501.096	Givosiran 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 RX501.096	Belimumab 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 Recommended Clinical Review (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 RX501.096	Benralizumab 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 RX501.096	Burosumab-twza 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 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 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 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 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 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 Recommended Clinical Review (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 RX501.096	Canakinumab 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 RX501.111	Specialty Medication Administration Site of Care 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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR717.001 RX501.076	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services 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 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 RX501.096	Specialty Medication Administration Site of Care 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 RX501.096	Specialty Medication Administration Site of Care 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 RX501.096	Ravulizumab-cwvz (Ultomiris) 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 Recommended Clinical Review (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 Recommended Clinical Review (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 RX501.067	Specialty Medication Administration Site of Care 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 RX501.067	Specialty Medication Administration Site of Care 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 RX504.003	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) 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 Recommended Clinical Review (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 RX504.003	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) 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 RX504.003	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) 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 RX504.003	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) 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 RX501.096	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) 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 RX504.003	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) 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 RX504.003	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) 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 RX504.003	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) 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 RX504.003	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) 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 RX504.003	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) 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 RX504.003	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) 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 RX504.003	Immunoglobulin (Ig) Therapy (Including Intravenous [IVIG] and Subcutaneous Ig [SCIG]) 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 RX501.096	Specialty Medication Administration Site of Care 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 RX501.067	Specialty Medication Administration Site of Care 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 RX501.096 THE801.028	Infliximab and Associated Biosimilars Specialty Medication Administration Site of Care 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 RX501.096	Ibalizumab-uiyk (Trogarzo) 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 RX501.067	Specialty Medication Administration Site of Care 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 Recommended Clinical Review (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 RX501.067	Specialty Medication Administration Site of Care 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 Recommended Clinical Review (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 RX501.080	Mepolizumab 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR717.001 RX501.076	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services 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 RX501.059	Specialty Medication Administration Site of Care 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 RX501.096	Ocrelizumab 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 Recommended Clinical Review (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 RX501.096	Specialty Medication Administration Site of Care 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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	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)	_	_
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 RX501.120		Specialty Medication Administration Site of Care 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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	OTH903.027 OTH903.015 OTH903.041		Intravitreal Angiogenesis Inhibitors for Retinal Vascular Disorders Photodynamic Therapy (PDT) for Choroidal Neovascularization (CNV) 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 Recommended Clinical Review (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 RX501.083		Reslizumab 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 Recommended Clinical Review (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 RX501.067		Specialty Medication Administration Site of Care 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 RX501.096		Eptinezumab-jjmr Specialty Medication Administration Site of Care	_	_
J3060	Injection Taliglucerase 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 RX501.096		Enzyme-Replacement Therapy for Lysosomal Storage Disorders 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 RX501.076		Gender Assignment Surgery and Gender Reassignment Surgery with Related Services 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 RX501.076		Gender Assignment Surgery and Gender Reassignment Surgery with Related Services 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 RX501.110		Specialty Medication Administration Site of Care 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 RX501.123		Specialty Medication Administration Site of Care 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 RX501.096		Tocilizumab 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	#N/A	#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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	RX501.041 RX501.040		Gonadotropin-Releasing Hormone (GnRH) Agonists and Antagonists 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 RX501.096		Specialty Medication Administration Site of Care 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 RX501.096		Specialty Medication Administration Site of Care 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 RX501.067		Specialty Medication Administration Site of Care 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 RX501.075	Hemophilia Agents 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	THE801.027 THE801.028	Dermatologic Applications of Photodynamic Therapy (PDT) 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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).	RXS01.063	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).	RXS01.063	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).	RXS01.063	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).	RXS01.063	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).	RXS01.063	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).	RXS01.063	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).	RXS01.063	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).	RXS01.063	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).	RXS01.063	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).	RXS01.063	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).	RXS01.063	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).	RXS01.063	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).	RXS01.063	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).	RXS01.063	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).	RXS01.063	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).	RXS01.063	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).	RXS01.063	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).	RXS01.063	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).	RXS01.063	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).	RXS01.063	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).	RXS01.063	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).	RXS01.063	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).	RXS01.063	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).	RXS01.063	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).	RXS01.063	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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 remov prem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3031	Foot lamin/prepreg composite	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3040	Ft arch suprt premold longit	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3050	Foot arch supp premold metat	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3060	Foot arch supp longitud/meta	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3070	Arch suprt att to sho longit	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3080	Arch supp att to shoe metata	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3090	Arch supp att to shoe long/m	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3100	Hallus-valgus nt dyn pre ots	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3140	Abduction rotation bar shoe	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3150	Abduct rotation bar w/o shoe	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3160	Shoe styled positioning dev	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3170	Foot plas heel stabi pre ots	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3201	Oxford w supinat/pronat inf	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3202	Oxford w/ supinat/pronator c	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3203	Oxford w/ supinator/pronator	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3204	Hightop w/ supp/pronator inf	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3206	Hightop w/ supp/pronator chi	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3207	Hightop w/ supp/pronator jun	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3212	Benesch boot pair infant	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3213	Benesch boot pair child	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3214	Benesch boot pair junior	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3215	Orthopedic ftwear ladies oxf	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3216	Orthoped ladies shoes dpth i	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3217	Ladies shoes hightop depth i	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3219	Orthopedic mens shoes oxford	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3221	Orthopedic mens shoes dpth i	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3222	Mens shoes hightop depth inl	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3224	Woman's shoe oxford brace	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3225	Man's shoe oxford brace	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3230	Custom shoes depth inlay	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3250	Custom mold shoe remov prost	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3251	Shoe molded to pt silicone s	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3252	Shoe molded plastazote cust	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3253	Shoe molded plastazote cust	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3254	Orth foot non-stndard size/w	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3255	Orth foot non-standard size/	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3257	Orth foot add charge split s	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3265	Plastazote sandal each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3300	Sho lift taper to metatarsal	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3310	Shoe lift elev heel/sole neo	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3320	Shoe lift elev heel/sole cor	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3330	Lifts elevation metal extens	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3332	Shoe lifts tapered to one-ha	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3334	Shoe lifts elevation heel /i	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3340	Shoe wedge sach	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3350	Shoe heel wedge	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3360	Shoe sole wedge outside sole	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3370	Shoe sole wedge between sole	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3380	Shoe clubfoot wedge	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3390	Shoe outflare wedge	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3400	Shoe metatarsal bar wedge ro	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3410	Shoe metatarsal bar between	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3420	Full sole/heel wedge btween	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3430	Sho heel count plast reinfor	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3440	Heel leather reinforced	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3450	Shoe heel sach cushion type	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3455	Shoe heel new leather standa	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3460	Shoe heel new rubber standar	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_

L3465	Shoe heel thomas with wedge	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3470	Shoe heel thomas extend to b	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3480	Shoe heel pad & depress for	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3485	Shoe heel pad removable for	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3500	Ortho shoe add leather insol	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3510	Orthopedic shoe add rub insl	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3520	O shoe add felt w leath insl	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3530	Ortho shoe add half sole	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3540	Ortho shoe add full sole	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3550	O shoe add standard toe tap	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3560	O shoe add horseshoe toe tap	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3570	O shoe add instep extension	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3580	O shoe add instep velcro clo	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3590	O shoe convert to sof counte	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3595	Ortho shoe add march bar	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3600	Trans shoe calip plate exist	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3610	Trans shoe caliper plate new	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3620	Trans shoe solid stirrup exi	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3630	Trans shoe solid stirrup new	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3640	Shoe dennis browne splint bo	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
L3649	Orthopedic shoe modifica NOS	Non Covered: Procedure/service not covered by 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Myoelectric Controlled Independently Articulating Digits Any Grasp Pattern Or Combination Of Grasp Patterns Includes Motor(S)	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	DME104.012 DME104.001	Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	DME104.012 DME104.001	Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	DME104.012 DME104.001	Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	DME104.012 DME104.001	Lower-Limb Prosthetics, Including Microprocessor-Controlled Prosthetics 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 Recommended Clinical Review (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 Recommended Clinical Review (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 SUR716.011 SUR716.010 DME104.001	Mastopexy Upper-Limb Prosthesis, Including Myoelectric and Orthotic Components, and Other Prosthetics Except for Lower-Limb Prosthesis Breast Implant, Removal and/or Insertion 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR710.022 SUR710.008	Injectable Bulking Agents for the Treatment of Urinary and Fecal Incontinence 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR710.022 SUR710.008	Injectable Bulking Agents for the Treatment of Urinary and Fecal Incontinence 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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	OTH903.030 SUR713.025	Keratoprosthesis 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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR712.025 MED205.032 SUR712.021 SUR712.033 SUR712.009	Deep Brain Stimulation (DBS) Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS) Vagus Nerve Stimulation (VNS) Spinal Cord Stimulation (SCS) and Dorsal Root Ganglion (DRG) Stimulation 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR710.018 SUR712.025 SUR709.031 MED205.032 SUR712.021 SUR712.039 SUR712.033 SUR712.009	Sacral Nerve Neuromodulation/Stimulation Gastric Electrical Stimulation (GES) Deep Brain Stimulation (DBS) Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS) Vagus Nerve Stimulation (VNS) Spinal Cord Stimulation (SCS) and Dorsal Root Ganglion (DRG) Stimulation Occipital Nerve Stimulation 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR712.033 MED205.036 SUR710.018 SUR712.021	Occipital Nerve Stimulation Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS) Sacral Nerve Neuromodulation/Stimulation 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR712.021 SUR712.033 MED205.032	Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS) Occipital Nerve Stimulation 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR712.021 SUR712.033 MED205.032	Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS) Occipital Nerve Stimulation 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR710.018 SUR712.025 SUR709.031 MED205.032 SUR712.021 SUR712.033 SUR712.009	Sacral Nerve Neuromodulation/Stimulation Gastric Electrical Stimulation (GES) Deep Brain Stimulation (DBS) Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS) Vagus Nerve Stimulation (VNS) Spinal Cord Stimulation (SCS) and Dorsal Root Ganglion (DRG) Stimulation 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR710.018 SUR712.025 SUR709.031 MED205.032 SUR712.021 SUR712.039 SUR712.033 SUR712.009	Sacral Nerve Neuromodulation/Stimulation Gastric Electrical Stimulation (GES) Deep Brain Stimulation (DBS) Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS) Vagus Nerve Stimulation (VNS) Spinal Cord Stimulation (SCS) and Dorsal Root Ganglion (DRG) Stimulation Occipital Nerve Stimulation 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR710.018 SUR712.025 SUR709.031 MED205.032 SUR712.021 SUR712.033 SUR712.009	Sacral Nerve Neuromodulation/Stimulation Gastric Electrical Stimulation (GES) Deep Brain Stimulation (DBS) Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS) Vagus Nerve Stimulation (VNS) Spinal Cord Stimulation (SCS) and Dorsal Root Ganglion (DRG) Stimulation 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR710.018 SUR712.025 SUR709.031 MED205.032 SUR712.021 SUR712.039 SUR712.033 SUR712.009	Sacral Nerve Neuromodulation/Stimulation Gastric Electrical Stimulation (GES) Deep Brain Stimulation (DBS) Peripheral Nerve Stimulation (PNS) And Peripheral Nerve Field Stimulation (PNFS) Vagus Nerve Stimulation (VNS) Spinal Cord Stimulation (SCS) and Dorsal Root Ganglion (DRG) Stimulation Occipital Nerve Stimulation 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR712.033 MED205.036 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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/integu p	EIU: Procedure/service not reimbursed by 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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	Kerramatrix 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Suredерm 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 RX501.096	Infliximab and Associated Biosimilars Specialty Medication 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 RX501.096	Infliximab and Associated Biosimilars Specialty Medication 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 SUR717.001 RX501.076	Gender Assignment Surgery and Gender Reassignment Surgery with Related Services Testosterone Replacement Therapies 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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					Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML) Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL)		
			SUR703.042				
			SUR703.033				
			SUR703.030				
			SUR703.037				
			SUR703.038				
			SUR703.034				
			SUR703.046				
			SUR703.050				
			SUR703.041				
			SUR703.036				
			SUR703.047				
			SUR703.029				
			SUR703.032				
			SUR703.031				
			SUR703.043				
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK	SUR703.045				
			SUR703.035				
			SUR703.040				
			SUR703.002				
			SUR703.044				
	Cord blood harvesting	Medical Policy criteria.	SUR703.039		Hematopoietic Cell Transplantation for	_	_
S2142					Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML) Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL)		
			SUR703.042				
			SUR703.033				
			SUR703.030				
			SUR703.037				
			SUR703.038				
			SUR703.034				
			SUR703.046				
			SUR703.050				
			SUR703.041				
			SUR703.036				
			SUR703.047				
			SUR703.029				
			SUR703.032				
			SUR703.031				
			SUR703.043				
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK	SUR703.045				
			SUR703.035				
			SUR703.040				
			SUR703.002				
			SUR703.044				
	Cord blood-derived stem-cell	Medical Policy criteria.	SUR703.039		Hematopoietic Cell Transplantation for	_	_
S2150					Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors Hematopoietic Cell Transplantation for Non-Hodgkin Lymphomas Hematopoietic Cell Transplantation for Acute Myelogenous Leukemia (AML) Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia (CML) Hematopoietic Cell Transplantation for Epithelial Ovarian Cancer Hematopoietic Cell Transplantation for Central Nervous System Embryonal Tumors and Ependymoma Hematopoietic Cell Transplantation for Hodgkin Lymphoma (HL) Hematopoietic Cell Transplantation (HCT) or Additional Infusion Following Preparative Regimens (General Donor and Recipient Information) Hematopoietic Cell Transplantation for Miscellaneous Solid Tumors in Adults Hematopoietic Cell Transplantation for Malignant Astrocytomas and Gliomas Hematopoietic Cell Transplantation for Breast Cancer Hematopoietic Cell Transplantation for Solid Tumors in Children Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemias Hematopoietic Cell Transplantation for Autoimmune Diseases Hematopoietic Cell Transplantation as a Treatment of Acute Lymphoblastic Leukemia (ALL)		
			SUR703.042				
			SUR703.033				
			SUR703.030				
			SUR703.037				
			SUR703.038				
			SUR703.034				
			SUR703.046				
			SUR703.050				
			SUR703.041				
			SUR703.036				
			SUR703.047				
			SUR703.029				
			SUR703.032				
			SUR703.031				
			SUR703.043				
		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK	SUR703.045				
			SUR703.035				
			SUR703.040				
			SUR703.002				
			SUR703.044				
	BMT harv/transpl 28d pkg	Medical Policy criteria.	SUR703.039		Hematopoietic Cell Transplantation for	_	_
S2202		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK					
	Echosclerotherapy	Medical Policy criteria.	SUR707.016		Varicose Vein Management	_	_
S2205		Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK					
	Minimally invasive direct co	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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	RAD601.038 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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	MED205.040 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	MED205.022 MED201.045 THE801.028 SUR702.005	Low-Level and High-Power Laser Therapy Acupuncture for Pain Management, Nausea and Vomiting and Opioid Dependence Treatment of Tinnitus 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	PSY301.014 THE803.014	Speech-Language Therapy (SLT) 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	THE801.008 PSY301.014	Chelation Therapy 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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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 Recommended Clinical Review (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.	_	_	_	_
T2014	Habil prevoc waiver per d	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T2015	Habil prevoc waiver per hr	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T2016	Habil res waiver per diem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T2017	Habil res waiver 15 min	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T2018	Habil sup empl waiver/diem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T2019	Habil sup empl waiver 15min	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T2020	Day habil waiver per diem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T2021	Day habil waiver per 15 min	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T2024	Serv asmnt/care plan waiver	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_	_
T2025	Waiver service nos	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_	_
T2026	Special childcare waiver/d	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T2027	Spec childcare waiver 15 min	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T2028	Special supply nos waiver	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T2029	Special med equip noswaiver	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T2030	Assist living waiver/month	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_	_
T2031	Assist living waiver/diem	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_	_
T2032	Res care nos waiver/month	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_	_
T2033	Res nos waiver per diem	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_	_
T2034	Crisis interven waiver/diem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T2035	Utility services waiver	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T2036	Camp overnite waiver/session	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T2037	Camp day waiver/session	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T2038	Comm trans waiver/service	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T2039	Vehicle mod waiver/service	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_

T2040	Financial mgt waiver/15min	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T2041	Support broker waiver/15 min	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T2049	N-ET; stretcher van mileage	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T2050	Financial Mgt Waiver/Diem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_		
T2051	Support broker waiver/diem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_		
T2101	Breast milk proc/store/dist	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T4521	Adult size brief/diaper sm	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T4522	Adult size brief/diaper med	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T4523	Adult size brief/diaper lg	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T4524	Adult size brief/diaper xl	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T4525	Adult size pull-on sm	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T4526	Adult size pull-on med	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T4527	Adult size pull-on lg	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T4528	Adult size pull-on xl	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T4529	Ped size brief/diaper sm/med	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T4530	Ped size brief/diaper lg	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T4531	Ped size pull-on sm/med	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T4532	Ped size pull-on lg	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T4533	Youth size brief/diaper	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T4534	Youth size pull-on	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T4535	Disposable liner/shield/pad	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T4536	Reusable pull-on any size	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T4537	Reusable underpad bed size	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T4538	Diaper serv reusable diaper	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T4539	Reuse diaper/brief any size	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T4540	Reusable underpad chair size	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T4541	Large disposable underpad	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T4542	Small disposable underpad	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T4543	Adult disp brief/diap abv xl	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T5001	Position seat spec orth need	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
T5999	Supply nos	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_	_
V2199	Lens single vision not oth c	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_	_
V2599	Contact lens/es other type	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_	_
V2627	Scleral cover shell	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	DME104.003	Therapeutic Lenses, Scleral Shell	_	_
V2629	Prosthetic eye other type	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_	_
V2702	Deluxe lens feature	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
V2745	Tint any color/solid/grad	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
V2756	Eye glass case	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
V2761	Mirror coating	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
V2762	Polarization any lens	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
V2782	Lens 1.54-1.65 p/1.60-1.79g	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
V2783	Lens >= 1.66 p/>=1.80 g	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
V2787	Astigmatism-correct function	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR713.025	Intraocular Lens (IOLs) and Implantable Miniature Telescope (IMT)	_	_
V2788	Presbyopia-correct function	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR713.025	Intraocular Lens (IOLs) and Implantable Miniature Telescope (IMT)	_	_
V2790	Amniotic membrane	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR704.011	Amniotic Membrane and Amniotic Fluid	_	_
V2797	Vis item/svc in other code	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_
V2799	Misc vision item or service	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_	_
V5090	Hearing aid dispensing fee	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_	_
V5095	Implant mid ear hearing pros	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	SUR714.008	Semi-Implantable and Fully Implantable Middle Ear Hearing Aids	_	_

V5267	Hearing aid sup/access/dev	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_	_	
V5269	Alerting device any type	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_	
V5270	ALD TV amplifier any type	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_	
V5271	ALD TV caption decoder	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_	
V5272	Tdd	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_	
V5273	ALD for cochlear implant	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_	
V5274	ALD unspecified	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_	_	
V5287	Ald fm/dm receiver NOS	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_	_	
V5298	Hearing aid noc	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_	_	
V5299	Hearing service	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_	_	
V5362	Speech screening	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	PSY301.014	Autism Spectrum Disorders (ASD)	_		6/30/2022
V5363	Language screening	Medical Policy Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	PSY301.014	Autism Spectrum Disorders (ASD)	_		6/30/2022

Updates		
Add effective 1/1/2023		Add effective 1/1/2023
Add effective 1/1/2023		Add effective 1/1/2023
Add effective 1/1/2023		Add effective 1/1/2023
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Add effective 01/01/2023		Add effective 1/1/2023

Add effective 12/15/2022		**Add effective 12/15/2022**
Add effective 12/15/2022		**Add effective 12/15/2022**
Add effective 01/01/2023		Add effective 01/01/2023
Add effective 01/01/2023		Add effective 01/01/2023
Remove effective 3/31/2023		**Remove effective 3/31/2023**

Add effective 4/1/2023
Add effective 10/01/2022; Move to EIU effective 04/01/2023
Add effective 4/1/2023
Add effective 10/01/2022; Move to EIU effective 04/01/2023
Add effective 4/1/2023
Add effective 10/01/2022; Move to EIU effective 04/01/2023
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