2024 Recommended Clinical Review (Predetermination), Post-Service Review and Non-Covered Procedure Code List
Effective 1/1/2024
(Updated June 2024)

This list includes Current Procedural Terminology (CPT®) and/or Healthcare Common Procedure Coding System (HCPCS) codes related to services/categories for which prior authorization may be required as of January 1, 2024 unles otherwise indicated through Blue Cross and Blue Shield of Oklahoma managed for one or more of our networks:

- Blue Choice Preferred PPO [SM]

- Blue Choice PPO [SM]

- Blue Traditional [SM]

For Medical Policy information, please access the BCBSOK Medical Policy Website

Utilization Management Process

This file is a searchable PDF.
Press "CTRL" and "F" keys at the same time to bring up the search box. Enter a procedure code or description of the service.

Procedure Code Groups	Procedure Code Group Description
Medical Policy Criteria (MP Criteria)	Procedures/services reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Highlighted procedure/service in this code group may require Prior Authorization per contract agreement.
Non Covered	Procedures/services not covered by the Plan. Not subject to pre-service review.
Experimental, Investigational, Unproven (EIU)	Procedures/services not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).
Unlisted or Undefined	Procedures/services not specifically defined or classified, may be subject to contract/clinical review.

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

Procedure Code	Code Description	Code Group & Description	Effective Date	Ending Date	Updates
00640	Anesthesia For Manipulation Of The Spine Or For Closed Procedures On The Cervical Thoracic Or Lumbar Spine	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
00797	Anesthesia For Intraperitoneal Procedures In Upper Abdomen Including Laparoscopy; Gastric Restrictive Procedure For Morbid Obesity	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

11055	Paring Or Cutting Of Benign Hyperkeratotic Lesion (Eg Corn Or Callus); Single Lesion	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
11056	Paring Or Cutting Of Benign Hyperkeratotic Lesion (Eg Corn Or Callus); 2 To 4 Lesions	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
11057	Paring Or Cutting Of Benign Hyperkeratotic Lesion (Eg Corn Or Callus); More Than 4 Lesions	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
11200	Removal Of Skin Tags Multiple Fibrocutaneous Tags Any Area; Up To And Including 15 Lesions	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
11201	Removal Of Skin Tags Multiple Fibrocutaneous Tags Any Area; Each Additional 10 Lesions Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
11719	Trimming Of Nondystrophic Nails Any Number	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
11920	Tattooing Intradermal Introduction Of Insoluble Opaque Pigments To Correct Color Defects Of Skin Including Micropigmentation; 6.0 Sq Cm Or Less	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
11921	Tattooing Intradermal Introduction Of Insoluble Opaque Pigments To Correct Color Defects Of Skin Including Micropigmentation; 6.1 To 20.0 Sq Cm	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	5/31/2024	Retire effective 5/31/2024
11922	Tattooing Intradermal Introduction Of Insoluble Opaque Pigments To Correct Color Defects Of Skin Including Micropigmentation; Each Additional 20.0 Sq Cm Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

11950	Subcutaneous Injection Of Filling Material (Eg Collagen); 1 Cc Or Less	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
11951	Subcutaneous Injection Of Filling Material (Eg Collagen); 1.1 To 5.0 Cc	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
11952	Subcutaneous Injection Of Filling Material (Eg Collagen); 5.1 To 10.0 Cc	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
11954	Subcutaneous Injection Of Filling Material (Eg Collagen); Over 10.0 Cc	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
11960	Insertion Of Tissue Expander(S) For Other Than Breast Including Subsequent Expansion	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
11980	Subcutaneous Hormone Pellet Implantation (Implantation Of Estradiol And/Or Testosterone Pellets Beneath The Skin)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
11981	Insertion Drug-Delivery Implant (Ie Bioresorbable Biodegradable Non-Biodegradable)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
11982	Removal Non-Biodegradable Drug Delivery Implant	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
11983	Removal With Reinsertion Non-Biodegradable Drug Delivery Implant	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

15271	Application Of Skin Substitute Graft To Trunk Arms Legs Total Wound Surface Area Up To 100 Sq Cm; First 25 Sq Cm Or Less Wound Surface Area	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
15272	Application Of Skin Substitute Graft To Trunk Arms Legs Total Wound Surface Area Up To 100 Sq Cm; Each Additional 25 Sq Cm Wound Surface Area Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
15273	Application Of Skin Substitute Graft To Trunk Arms Legs Total Wound Surface Area Greater Than Or Equal To 100 Sq Cm; First 100 Sq Cm Wound Surface Area Or 1% Of Body Area Of Infants And Children	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
15274	Application Of Skin Substitute Graft To Trunk Arms Legs Total Wound Surface Area Greater Than Or Equal To 100 Sq Cm; Each Additional 100 Sq Cm Wound Surface Area Or Part Thereof Or Each Additional 1% Of Body Area Of Infants And Children Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
15275	Application Of Skin Substitute Graft To Face Scalp Eyelids Mouth Neck Ears Orbits Genitalia Hands Feet And/Or Multiple Digits Total Wound Surface Area Up To 100 Sq Cm; First 25 Sq Cm Or Less Wound Surface Area	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
15276	Application Of Skin Substitute Graft To Face Scalp Eyelids Mouth Neck Ears Orbits Genitalia Hands Feet And/Or Multiple Digits Total Wound Surface Area Up To 100 Sq Cm; Each Additional 25 Sq Cm Wound Surface Area Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
15277	Application Of Skin Substitute Graft To Face Scalp Eyelids Mouth Neck Ears Orbits Genitalia Hands Feet And/Or Multiple Digits Total Wound Surface Area Greater Than Or Equal To 100 Sq Cm; First 100 Sq Cm Wound Surface Area Or 1% Of Body Area Of Infants And Children	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
15278	Application Of Skin Substitute Graft To Face Scalp Eyelids Mouth Neck Ears Orbits Genitalia Hands Feet And/Or Multiple Digits Total Wound Surface Area Greater Than Or Equal To 100 Sq Cm; Each Additional 100 Sq Cm Wound Surface Area Or Part Thereof Or Each Additional 1% Of Body Area Of Infants And Children Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

15758	Free Fascial Flap With Microvascular Anastomosis	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
15771	Grafting Of Autologous Fat Harvested By Liposuction Technique To Trunk Breasts Scalp Arms And/Or Legs; 50 Cc Or Less Injectate	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
15772	Grafting Of Autologous Fat Harvested By Liposuction Technique To Trunk Breasts Scalp Arms And/Or Legs; Each Additional 50 Cc Injectate Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
15775	Punch Graft For Hair Transplant; 1 To 15 Punch Grafts	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
15776	Punch Graft For Hair Transplant; More Than 15 Punch Grafts	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
15780	Dermabrasion; Total Face (Eg For Acne Scarring Fine Wrinkling Rhytids General Keratosis)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
15781	Dermabrasion; Segmental Face	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
15782	Dermabrasion; Regional Other Than Face	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
15783	Dermabrasion; Superficial Any Site (Eg Tattoo Removal)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

15786	Abrasion; Single Lesion (Eg Keratosis Scar)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
15787	Abrasion; Each Additional 4 Lesions Or Less (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
15788	Chemical Peel Facial; Epidermal	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
15789	Chemical Peel Facial; Dermal	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
15792	Chemical Peel Nonfacial; Epidermal	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
15793	Chemical Peel Nonfacial; Dermal	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
15819	Cervicoplasty	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
15820	Blepharoplasty Lower Eyelid;	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
15821	Blepharoplasty Lower Eyelid; With Extensive Herniated Fat Pad	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
15822	Blepharoplasty Upper Eyelid;	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

15823	Blepharoplasty Upper Eyelid; With Excessive Skin Weighting Down Lid	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
15825	Rhytidectomy; Neck With Platysmal Tightening (Platysmal Flap P-Flap)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
15828	Rhytidectomy; Cheek Chin And Neck	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
15829	Rhytidectomy; Superficial Musculoaponeurotic System (Smas) Flap	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
15830	Excision Excessive Skin And Subcutaneous Tissue (Includes Lipectomy); Abdomen Infraumbilical Panniculectomy	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
15832	Excision Excessive Skin And Subcutaneous Tissue (Includes Lipectomy); Thigh	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
15833	Excision Excessive Skin And Subcutaneous Tissue (Includes Lipectomy); Leg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
15834	Excision Excessive Skin And Subcutaneous Tissue (Includes Lipectomy); Hip	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
15835	Excision Excessive Skin And Subcutaneous Tissue (Includes Lipectomy); Buttock	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

15836	Excision Excessive Skin And Subcutaneous Tissue (Includes Lipectomy); Arm	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
15837	Excision Excessive Skin And Subcutaneous Tissue (Includes Lipectomy); Forearm Or Hand	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
15838	Excision Excessive Skin And Subcutaneous Tissue (Includes Lipectomy); Submental Fat Pad	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
15839	Excision Excessive Skin And Subcutaneous Tissue (Includes Lipectomy); Other Area	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
15847	Excision Excessive Skin And Subcutaneous Tissue (Includes Lipectomy) Abdomen (Eg Abdominoplasty) (Includes Umbilical Transposition And Fascial Plication) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
15876	Suction Assisted Lipectomy; Head And Neck	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
15877	Suction Assisted Lipectomy; Trunk	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
15878	Suction Assisted Lipectomy; Upper Extremity	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
15879	Suction Assisted Lipectomy; Lower Extremity	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

15999	Unlisted Procedure Excision Pressure Ulcer	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
17106	Destruction Of Cutaneous Vascular Proliferative Lesions (Eg Laser Technique); Less Than 10 Sq Cm	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
17107	Destruction Of Cutaneous Vascular Proliferative Lesions (Eg Laser Technique); 10.0 To 50.0 Sq Cm	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
17108	Destruction Of Cutaneous Vascular Proliferative Lesions (Eg Laser Technique); Over 50.0 Sq Cm	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
17340	Cryotherapy (Co2 Slush Liquid N2) For Acne	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
17360	Chemical Exfoliation For Acne (Eg Acne Paste Acid)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
17380	Electrolysis Epilation Each 30 Minutes	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
17999	Unlisted Procedure Skin Mucous Membrane And Subcutaneous Tissue	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
19105	Ablation Cryosurgical Of Fibroadenoma Including Ultrasound Guidance Each Fibroadenoma	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
19300	Mastectomy For Gynecomastia	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

19303	Mastectomy Simple Complete	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
19325	Breast Augmentation With Implant	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
19328	Removal Of Intact Breast Implant	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
19330	Removal Of Ruptured Breast Implant Including Implant Contents (Eg Saline Silicone Gel)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
19340	Insertion Of Breast Implant On Same Day Of Mastectomy (Ie Immediate)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
19342	Insertion Or Replacement Of Breast Implant On Separate Day From Mastectomy	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
19350	Nipple/Areola Reconstruction	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
19355	Correction Of Inverted Nipples	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
19357	Tissue Expander Placement In Breast Reconstruction Including Subsequent Expansion(S)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

19370	Revision Of Peri-Implant Capsule Breast Including Capsulotomy Capsulorrhaphy And/Or Partial Capsulectomy	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
19371	Peri-Implant Capsulectomy Breast Complete Including Removal Of All Intracapsular Contents	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
19499	Unlisted Procedure Breast	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
20527	Injection Enzyme (Eg Collagenase) Palmar Fascial Cord (Ie Dupuytren'S Contracture)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
20560	Needle Insertion(S) Without Injection(S); 1 Or 2 Muscle(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).	_	_	_
20561	Needle Insertion(S) Without Injection(S); 3 Or More Muscles	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
20979	Low Intensity Ultrasound Stimulation To Aid Bone Healing Noninvasive (Nonoperative)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
20982	Ablation Therapy For Reduction Or Eradication Of 1 Or More Bone Tumors (Eg Metastasis) Including Adjacent Soft Tissue When Involved By Tumor Extension Percutaneous Including Imaging Guidance When Performed; Radiofrequency	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
20983	Ablation Therapy For Reduction Or Eradication Of 1 Or More Bone Tumors (Eg Metastasis) Including Adjacent Soft Tissue When Involved By Tumor Extension Percutaneous Including Imaging Guidance When Performed; Cryoablation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_

20985	Computer-Assisted Surgical Navigational Procedure For Musculoskeletal Procedures Image-Less (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
20999	Unlisted Procedure Musculoskeletal System General	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
21073	Manipulation Of Temporomandibular Joint(S) (Tmj) Therapeutic Requiring An Anesthesia Service (Ie General Or Monitored Anesthesia Care)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
21083	Impression And Custom Preparation; Palatal Lift Prosthesis	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
21089	Unlisted Maxillofacial Prosthetic Procedure	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
21120	Genioplasty; Augmentation (Autograft Allograft Prosthetic Material)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
21121	Genioplasty; Sliding Osteotomy Single Piece	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
21122	Genioplasty; Sliding Osteotomies 2 Or More Osteotomies (Eg Wedge Excision Or Bone Wedge Reversal For Asymmetrical Chin)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
21123	Genioplasty; Sliding Augmentation With Interpositional Bone Grafts (Includes Obtaining Autografts)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
21244	Reconstruction Of Mandible Extraoral With Transosteal Bone Plate (Eg Mandibular Staple Bone Plate)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

21245	Reconstruction Of Mandible Or Maxilla Subperiosteal Implant; Partial	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
21246	Reconstruction Of Mandible Or Maxilla Subperiosteal Implant; Complete	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
21247	Reconstruction Of Mandibular Condyle With Bone And Cartilage Autografts (Includes Obtaining Grafts) (Eg For Hemifacial Microsomia)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
21248	Reconstruction Of Mandible Or Maxilla Endosteal Implant (Eg Blade Cylinder); Partial	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
21249	Reconstruction Of Mandible Or Maxilla Endosteal Implant (Eg Blade Cylinder); Complete	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
21299	Unlisted Craniofacial And Maxillofacial Procedure	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
21499	Unlisted Musculoskeletal Procedure Head	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
21685	Hyoid Myotomy And Suspension	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
21740	Reconstructive Repair Of Pectus Excavatum Or Carinatum; Open	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
21742	Reconstructive Repair Of Pectus Excavatum Or Carinatum; Minimally Invasive Approach (Nuss Procedure) Without Thoracoscopy	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

21743	Reconstructive Repair Of Pectus Excavatum Or Carinatum; Minimally Invasive Approach (Nuss Procedure) With Thoracoscopy	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
21899	Unlisted Procedure Neck Or Thorax	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
22505	Manipulation Of Spine Requiring Anesthesia Any Region	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
22526	Percutaneous Intradiscal Electrothermal Annuloplasty Unilateral Or Bilateral Including Fluoroscopic Guidance; Single Level	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
22527	Percutaneous Intradiscal Electrothermal Annuloplasty Unilateral Or Bilateral Including Fluoroscopic Guidance; 1 Or More Additional Levels (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
22586	Arthrodesis Pre-Sacral Interbody Technique Including Disc Space Preparation Discectomy With Posterior Instrumentation With Image Guidance Includes Bone Graft When Performed L5-S1 Interspace	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
22836	Anterior Thoracic Vertebral Body Tethering Including Thoracoscopy When Performed; Up To 7 Vertebral Segments	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	5/14/2024	Retire effective 05/14/2024
22836	Anterior Thoracic Vertebral Body Tethering Including Thoracoscopy When Performed; Up To 7 Vertebral Segments	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024
22837	Anterior Thoracic Vertebral Body Tethering Including Thoracoscopy When Performed; 8 Or More Vertebral Segments	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	5/14/2024	Retire effective 05/14/2024
22837	Anterior Thoracic Vertebral Body Tethering Including Thoracoscopy When Performed; 8 Or More Vertebral Segments	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024
22838	Revision (Eg Augmentation Division Of Tether) Replacement Or Removal Of Thoracic Vertebral Body Tethering Including Thoracoscopy When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	5/14/2024	Retire effective 05/14/2024
22838	Revision (Eg Augmentation Division Of Tether) Replacement Or Removal Of Thoracic Vertebral Body Tethering Including Thoracoscopy When Performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024
22867	Insertion Of Interlaminar/Interspinous Process Stabilization/Distraction Device Without Fusion Including Image Guidance When Performed With Open Decompression Lumbar; 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).	_	_	_

22868	Insertion Of Interlaminar/Interspinous Process Stabilization/Distraction Device Without Fusion Including Image Guidance When Performed With Open Decompression Lumbar; Second Level (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
22869	Insertion Of Interlaminar/Interspinous Process Stabilization/Distraction Device Without Open Decompression Or Fusion Including Image Guidance When Performed Lumbar; 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).	_	_	_
22870	Insertion Of Interlaminar/Interspinous Process Stabilization/Distraction Device Without Open Decompression Or Fusion Including Image Guidance When Performed Lumbar; Second Level (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
22899	Unlisted Procedure Spine	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
22999	Unlisted Procedure Abdomen Musculoskeletal System	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
23929	Unlisted Procedure Shoulder	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
24300	Manipulation Elbow Under Anesthesia	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
24999	Unlisted Procedure Humerus Or Elbow	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
25259	Manipulation Wrist Under Anesthesia	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

25999	Unlisted Procedure Forearm Or Wrist	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
26340	Manipulation Finger Joint Under Anesthesia Each Joint	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
26341	Manipulation Palmar Fascial Cord (Ie Dupuytren'S Cord) Post Enzyme Injection (Eg Collagenase) Single Cord	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
26989	Unlisted Procedure Hands Or Fingers	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
27257	Treatment Of Spontaneous Hip Dislocation (Developmental Including Congenital Or Pathological) By Abduction Splint Or Traction; With Manipulation Requiring Anesthesia	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
27275	Manipulation Hip Joint Requiring General Anesthesia	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
27278	Arthrodesis Sacroiliac Joint Percutaneous With Image Guidance Including Placement Of Intra-Articular Implant(S) (Eg Bone Allograft[S] Synthetic Device[S]) Without Placement Of Transfixation Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	5/14/2024	Retire effective 05/14/2024
27278	Arthrodesis Sacroiliac Joint Percutaneous With Image Guidance Including Placement Of Intra-Articular Implant(S) (Eg Bone Allograft[S] Synthetic Device[S]) Without Placement Of Transfixation Device	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024
27299	Unlisted Procedure Pelvis Or Hip Joint	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
27599	Unlisted Procedure Femur Or Knee	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_

27702	Arthroplasty Ankle; With Implant (Total Ankle)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
27703	Arthroplasty Ankle; Revision Total Ankle	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
27704	Removal Of Ankle Implant	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
27860	Manipulation Of Ankle Under General Anesthesia (Includes Application Of Traction Or Other Fixation Apparatus)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
27899	Unlisted Procedure Leg Or Ankle	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
28890	Extracorporeal Shock Wave High Energy Performed By A Physician Or Other Qualified Health Care Professional Requiring Anesthesia Other Than Local Including Ultrasound Guidance Involving The Plantar Fascia	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
28899	Unlisted Procedure Foot Or Toes	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
29799	Unlisted Procedure Casting Or Strapping	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
29862	Arthroscopy Hip Surgical; With Debridement/Shaving Of Articular Cartilage (Chondroplasty) Abrasion Arthroplasty And/Or Resection Of Labrum	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
29866	Arthroscopy Knee Surgical; Osteochondral Autograft(S) (Eg Mosaicplasty) (Includes Harvesting Of The Autograft[S])	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

29867	Arthroscopy Knee Surgical; Osteochondral Allograft (Eg Mosaicplasty)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
29868	Arthroscopy Knee Surgical; Meniscal Transplantation (Includes Arthrotomy For Meniscal Insertion) Medial Or Lateral	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
29914	Arthroscopy Hip Surgical; With Femoroplasty (Ie Treatment Of Cam Lesion)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
29915	Arthroscopy Hip Surgical; With Acetabuloplasty (Ie Treatment Of Pincer Lesion)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
29916	Arthroscopy Hip Surgical; With Labral Repair	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
29999	Unlisted Procedure Arthroscopy	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
30468	Repair Of Nasal Valve Collapse With Subcutaneous/Submucosal Lateral Wall Implant(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).	_	_	_
30469	Repair Of Nasal Valve Collapse With Low Energy Temperature-Controlled (Ie Radiofrequency) Subcutaneous/Submucosal Remodeling	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
30999	Unlisted Procedure Nose	Unlisted Procedure; May require Prior Authorization per contract agreement.	_	_	_
31242	Nasal/Sinus Endoscopy Surgical; With Destruction By Radiofrequency Ablation Posterior Nasal Nerve	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	5/14/2024	Retire effective 05/14/2024

31242	Nasal/Sinus Endoscopy Surgical; With Destruction By Radiofrequency Ablation Posterior Nasal Nerve	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024
31243	Nasal/Sinus Endoscopy Surgical; With Destruction By Cryoablation Posterior Nasal Nerve	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	5/14/2024	Retire effective 05/14/2024
31243	Nasal/Sinus Endoscopy Surgical; With Destruction By Cryoablation Posterior Nasal Nerve	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024
31295	Nasal/Sinus Endoscopy Surgical With Dilation (Eg Balloon Dilation); Maxillary Sinus Ostium Transnasal Or Via Canine Fossa	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
31298	Nasal/Sinus Endoscopy Surgical With Dilation (Eg Balloon Dilation); Frontal And Sphenoid Sinus Ostia	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
31299	Unlisted Procedure Accessory Sinuses	Unlisted Procedure; May require Prior Authorization per contract agreement.	_	_	_
31573	Laryngoscopy Flexible; With Therapeutic Injection(S) (Eg Chemodenervation Agent Or Corticosteroid Injected Percutaneous Transoral Or Via Endoscope Channel) Unilateral	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
31574	Laryngoscopy Flexible; With Injection(S) For Augmentation (Eg Percutaneous Transoral) Unilateral	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
31599	Unlisted Procedure Larynx	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
31627	Bronchoscopy Rigid Or Flexible Including Fluoroscopic Guidance When Performed; With Computer-Assisted Image-Guided Navigation (List Separately In Addition To Code For Primary Procedure[S])	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
31634	Bronchoscopy Rigid Or Flexible Including Fluoroscopic Guidance When Performed; With Balloon Occlusion With Assessment Of Air Leak With Administration Of Occlusive Substance (Eg Fibrin Glue) If Performed	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

31647	Bronchoscopy Rigid Or Flexible Including Fluoroscopic Guidance When Performed; With Balloon Occlusion When Performed Assessment Of Air Leak Airway Sizing And Insertion Of Bronchial Valve(S) Initial Lobe	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
31648	Bronchoscopy Rigid Or Flexible Including Fluoroscopic Guidance When Performed; With Removal Of Bronchial Valve(S) Initial Lobe	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
31649	Bronchoscopy Rigid Or Flexible Including Fluoroscopic Guidance When Performed; With Removal Of Bronchial Valve(S) Each Additional Lobe (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
31651	Bronchoscopy Rigid Or Flexible Including Fluoroscopic Guidance When Performed; With Balloon Occlusion When Performed Assessment Of Air Leak Airway Sizing And Insertion Of Bronchial Valve(S) Each Additional Lobe (List Separately In Addition To Code For Primary Procedure[S])	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
31660	Bronchoscopy Rigid Or Flexible Including Fluoroscopic Guidance When Performed; With Bronchial Thermoplasty 1 Lobe	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
31661	Bronchoscopy Rigid Or Flexible Including Fluoroscopic Guidance When Performed; With Bronchial Thermoplasty 2 Or More Lobes	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
31899	Unlisted Procedure Trachea Bronchi	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
32553	Placement Of Interstitial Device(S) For Radiation Therapy Guidance (Eg Fiducial Markers Dosimeter) Percutaneous Intra-Thoracic Single Or Multiple	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
32664	Thoracoscopy Surgical; With Thoracic Sympathectomy	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

32994	Ablation Therapy For Reduction Or Eradication Of 1 Or More Pulmonary Tumor(S) Including Pleura Or Chest Wall When Involved By Tumor Extension Percutaneous Including Imaging Guidance When Performed Unilateral; Cryoablation	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
32998	Ablation Therapy For Reduction Or Eradication Of 1 Or More Pulmonary Tumor(S) Including Pleura Or Chest Wall When Involved By Tumor Extension Percutaneous Including Imaging Guidance When Performed Unilateral; Radiofrequency	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
32999	Unlisted Procedure Lungs And Pleura	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
33211	Insertion Or Replacement Of Temporary Transvenous Dual Chamber Pacing Electrodes (Separate Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
33213	Insertion Of Pacemaker Pulse Generator Only; With Existing Dual Leads	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
33225	Insertion Of Pacing Electrode Cardiac Venous System For Left Ventricular Pacing At Time Of Insertion Of Implantable Defibrillator Or Pacemaker Pulse Generator (Eg For Upgrade To Dual Chamber System) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
33267	Exclusion Of Left Atrial Appendage Open Any Method (Eg Excision Isolation Via Stapling Oversewing Ligation Plication Clip)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
33268	Exclusion Of Left Atrial Appendage Open Performed At The Time Of Other Sternotomy Or Thoracotomy Procedure(S) Any Method (Eg Excision Isolation Via Stapling Oversewing Ligation Plication Clip) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
33269	Exclusion Of Left Atrial Appendage Thoracoscopic Any Method (Eg Excision Isolation Via Stapling Oversewing Ligation Plication Clip)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

33270	Insertion Or Replacement Of Permanent Subcutaneous Implantable Defibrillator System With Subcutaneous Electrode Including Defibrillation Threshold Evaluation Induction Of Arrhythmia Evaluation Of Sensing For Arrhythmia Termination And Programming Or Reprogramming Of Sensing Or Therapeutic Parameters When Performed	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
33271	Insertion Of Subcutaneous Implantable Defibrillator Electrode	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
33274	Transcatheter Insertion Or Replacement Of Permanent Leadless Pacemaker Right Ventricular Including Imaging Guidance (Eg Fluoroscopy Venous Ultrasound Ventriculography Femoral Venography) And Device Evaluation (Eg Interrogation Or Programming) When Performed	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
33275	Transcatheter Removal Of Permanent Leadless Pacemaker Right Ventricular Including Imaging Guidance (Eg Fluoroscopy Venous Ultrasound Ventriculography Femoral Venography) When Performed	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
33276	Insertion Of Phrenic Nerve Stimulator System (Pulse Generator And Stimulating Lead[S]) Including Vessel Catheterization All Imaging Guidance And Pulse Generator Initial Analysis With Diagnostic Mode Activation When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	5/14/2024	Retire effective 05/14/2024
33276	Insertion Of Phrenic Nerve Stimulator System (Pulse Generator And Stimulating Lead[S]) Including Vessel Catheterization All Imaging Guidance And Pulse Generator Initial Analysis With Diagnostic Mode Activation When Performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024
33277	Insertion Of Phrenic Nerve Stimulator Transvenous Sensing Lead (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	5/14/2024	Retire effective 05/14/2024
33277	Insertion Of Phrenic Nerve Stimulator Transvenous Sensing Lead (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024
33278	Removal Of Phrenic Nerve Stimulator Including Vessel Catheterization All Imaging Guidance And Interrogation And Programming When Performed; System Including Pulse Generator And Lead(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	5/14/2024	Retire effective 05/14/2024
33278	Removal Of Phrenic Nerve Stimulator Including Vessel Catheterization All Imaging Guidance And Interrogation And Programming When Performed; System Including Pulse Generator And Lead(S)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024

33279	Removal Of Phrenic Nerve Stimulator Including Vessel Catheterization All Imaging Guidance And Interrogation And Programming When Performed; Transvenous Stimulation Or Sensing Lead(S) Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	5/14/2024	Retire effective 05/14/2024
33279	Removal Of Phrenic Nerve Stimulator Including Vessel Catheterization All Imaging Guidance And Interrogation And Programming When Performed; Transvenous Stimulation Or Sensing Lead(S) Only	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024
33280	Removal Of Phrenic Nerve Stimulator Including Vessel Catheterization All Imaging Guidance And Interrogation And Programming When Performed; Pulse Generator Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	5/14/2024	Retire effective 05/14/2024
33280	Removal Of Phrenic Nerve Stimulator Including Vessel Catheterization All Imaging Guidance And Interrogation And Programming When Performed; Pulse Generator Only	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024
33281	Repositioning Of Phrenic Nerve Stimulator Transvenous Lead(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	5/14/2024	Retire effective 05/14/2024
33281	Repositioning Of Phrenic Nerve Stimulator Transvenous Lead(S)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024
33285	Insertion Subcutaneous Cardiac Rhythm Monitor Including Programming	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
33287	Removal And Replacement Of Phrenic Nerve Stimulator Including Vessel Catheterization All Imaging Guidance And Interrogation And Programming When Performed; Pulse Generator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	5/14/2024	Retire effective 05/14/2024
33287	Removal And Replacement Of Phrenic Nerve Stimulator Including Vessel Catheterization All Imaging Guidance And Interrogation And Programming When Performed; Pulse Generator	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024
33288	Removal And Replacement Of Phrenic Nerve Stimulator Including Vessel Catheterization All Imaging Guidance And Interrogation And Programming When Performed; Transvenous Stimulation Or Sensing Lead(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	5/14/2024	Retire effective 05/14/2024
33288	Removal And Replacement Of Phrenic Nerve Stimulator Including Vessel Catheterization All Imaging Guidance And Interrogation And Programming When Performed; Transvenous Stimulation Or Sensing Lead(S)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024

33289	Transcatheter Implantation Of Wireless Pulmonary Artery Pressure Sensor For Long-Term Hemodynamic Monitoring Including Deployment And Calibration Of The Sensor Right Heart Catheterization Selective Pulmonary Catheterization Radiological Supervision And Interpretation And Pulmonary Artery Angiography When Performed	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
33340	Percutaneous Transcatheter Closure Of The Left Atrial Appendage With Endocardial Implant Including Fluoroscopy Transseptal Puncture Catheter Placement(S) Left Atrial Angiography Left Atrial Appendage Angiography When Performed And Radiological Supervision And Interpretation	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
33361	Transcatheter Aortic Valve Replacement (Tavr/Tavi) With Prosthetic Valve; Percutaneous Femoral Artery Approach	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
33362	Transcatheter Aortic Valve Replacement (Tavr/Tavi) With Prosthetic Valve; Open Femoral Artery Approach	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
33363	Transcatheter Aortic Valve Replacement (Tavr/Tavi) With Prosthetic Valve; Open Axillary Artery Approach	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
33364	Transcatheter Aortic Valve Replacement (Tavr/Tavi) With Prosthetic Valve; Open Iliac Artery Approach	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
33365	Transcatheter Aortic Valve Replacement (Tavr/Tavi) With Prosthetic Valve; Transaortic Approach (Eg Median Sternotomy Mediastinotomy)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
33366	Transcatheter Aortic Valve Replacement (Tavr/Tavi) With Prosthetic Valve; Transapical Exposure (Eg Left Thoracotomy)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

33367	Transcatheter Aortic Valve Replacement (Tavr/Tavi) With Prosthetic Valve; Cardiopulmonary Bypass Support With Percutaneous Peripheral Arterial And Venous Cannulation (Eg Femoral Vessels) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
33368	Transcatheter Aortic Valve Replacement (Tavr/Tavi) With Prosthetic Valve; Cardiopulmonary Bypass Support With Open Peripheral Arterial And Venous Cannulation (Eg Femoral Iliac Axillary Vessels) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
33369	Transcatheter Aortic Valve Replacement (Tavr/Tavi) With Prosthetic Valve; Cardiopulmonary Bypass Support With Central Arterial And Venous Cannulation (Eg Aorta Right Atrium Pulmonary Artery) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
33418	Transcatheter Mitral Valve Repair Percutaneous Approach Including Transseptal Puncture When Performed; Initial Prosthesis	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
33419	Transcatheter Mitral Valve Repair Percutaneous Approach Including Transseptal Puncture When Performed; Additional Prosthesis(Es) During Same Session (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
33477	Transcatheter Pulmonary Valve Implantation Percutaneous Approach Including Pre-Stenting Of The Valve Delivery Site When Performed	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
33542	Myocardial Resection (Eg Ventricular Aneurysmectomy)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
33880	Endovascular Repair Of Descending Thoracic Aorta (Eg Aneurysm Pseudoaneurysm Dissection Penetrating Ulcer Intramural Hematoma Or Traumatic Disruption); Involving Coverage Of Left Subclavian Artery Origin Initial Endoprosthesis Plus Descending Thoracic Aortic Extension(S) If Required To Level Of Celiac Artery Origin	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
33881	Endovascular Repair Of Descending Thoracic Aorta (Eg Aneurysm Pseudoaneurysm Dissection Penetrating Ulcer Intramural Hematoma Or Traumatic Disruption); Not Involving Coverage Of Left Subclavian Artery Origin Initial Endoprosthesis Plus Descending Thoracic Aortic Extension(S) If Required To Level Of Celiac Artery Origin	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

33883	Placement Of Proximal Extension Prosthesis For Endovascular Repair Of Descending Thoracic Aorta (Eg Aneurysm Pseudoaneurysm Dissection Penetrating Ulcer Intramural Hematoma Or Traumatic Disruption); Initial Extension	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
33884	Placement Of Proximal Extension Prosthesis For Endovascular Repair Of Descending Thoracic Aorta (Eg Aneurysm Pseudoaneurysm Dissection Penetrating Ulcer Intramural Hematoma Or Traumatic Disruption); Each Additional Proximal Extension (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
33886	Placement Of Distal Extension Prosthesis(S) Delayed After Endovascular Repair Of Descending Thoracic Aorta	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
33889	Open Subclavian To Carotid Artery Transposition Performed In Conjunction With Endovascular Repair Of Descending Thoracic Aorta By Neck Incision Unilateral	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
33927	Implantation Of A Total Replacement Heart System (Artificial Heart) With Recipient Cardiectomy	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
33928	Removal And Replacement Of Total Replacement Heart System (Artificial Heart)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
33929	Removal Of A Total Replacement Heart System (Artificial Heart) For Heart Transplantation (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
33975	Insertion Of Ventricular Assist Device; Extracorporeal Single Ventricle	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
33976	Insertion Of Ventricular Assist Device; Extracorporeal Biventricular	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

33979	Insertion Of Ventricular Assist Device Implantable Intracorporeal Single Ventricle	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
33981	Replacement Of Extracorporeal Ventricular Assist Device Single Or Biventricular Pump(S) Single Or Each Pump	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
33982	Replacement Of Ventricular Assist Device Pump(S); Implantable Intracorporeal Single Ventricle Without Cardiopulmonary Bypass	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
33983	Replacement Of Ventricular Assist Device Pump(S); Implantable Intracorporeal Single Ventricle With Cardiopulmonary Bypass	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
33990	Insertion Of Ventricular Assist Device Percutaneous Including Radiological Supervision And Interpretation; Left Heart Arterial Access Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
33991	Insertion Of Ventricular Assist Device Percutaneous Including Radiological Supervision And Interpretation; Left Heart Both Arterial And Venous Access With Transseptal Puncture	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
33992	Removal Of Percutaneous Left Heart Ventricular Assist Device Arterial Or Arterial And Venous Cannula(S) At Separate And Distinct Session From Insertion	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
33993	Repositioning Of Percutaneous Right Or Left Heart Ventricular Assist Device With Imaging Guidance At Separate And Distinct Session From Insertion	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

33999	Unlisted Procedure Cardiac Surgery	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
36260	Insertion Of Implantable Intra-Arterial Infusion Pump (Eg For Chemotherapy Of Liver)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
36299	Unlisted Procedure Vascular Injection	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
36465	Injection Of Non-Compounded Foam Sclerosant With Ultrasound Compression Maneuvers To Guide Dispersion Of The Injectate Inclusive Of All Imaging Guidance And Monitoring; Single Incompetent Extremity Truncal Vein (Eg Great Saphenous Vein Accessory Saphenous Vein)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
36466	Injection Of Non-Compounded Foam Sclerosant With Ultrasound Compression Maneuvers To Guide Dispersion Of The Injectate Inclusive Of All Imaging Guidance And Monitoring; Multiple Incompetent Truncal Veins (Eg Great Saphenous Vein Accessory Saphenous Vein) Same Leg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
36468	Injection(S) Of Sclerosant For Spider Veins (Telangiectasia) Limb Or Trunk	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
36470	Injection Of Sclerosant; Single Incompetent Vein (Other Than Telangiectasia)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
36471	Injection Of Sclerosant; Multiple Incompetent Veins (Other Than Telangiectasia) Same Leg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
36473	Endovenous Ablation Therapy Of Incompetent Vein Extremity Inclusive Of All Imaging Guidance And Monitoring Percutaneous Mechanochemical; First Vein Treated	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_

36474	Endovenous Ablation Therapy Of Incompetent Vein Extremity Inclusive Of All Imaging Guidance And Monitoring Percutaneous Mechanochemical; Subsequent Vein(S) Treated In A Single Extremity Each Through Separate Access Sites (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
36475	Endovenous Ablation Therapy Of Incompetent Vein Extremity Inclusive Of All Imaging Guidance And Monitoring Percutaneous Radiofrequency; First Vein Treated	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
36476	Endovenous Ablation Therapy Of Incompetent Vein Extremity Inclusive Of All Imaging Guidance And Monitoring Percutaneous Radiofrequency; Subsequent Vein(S) Treated In A Single Extremity Each Through Separate Access Sites (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
36478	Endovenous Ablation Therapy Of Incompetent Vein Extremity Inclusive Of All Imaging Guidance And Monitoring Percutaneous Laser; First Vein Treated	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
36479	Endovenous Ablation Therapy Of Incompetent Vein Extremity Inclusive Of All Imaging Guidance And Monitoring Percutaneous Laser; Subsequent Vein(S) Treated In A Single Extremity Each Through Separate Access Sites (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
36482	Endovenous Ablation Therapy Of Incompetent Vein Extremity By Transcatheter Delivery Of A Chemical Adhesive (Eg Cyanoacrylate) Remote From The Access Site Inclusive Of All Imaging Guidance And Monitoring Percutaneous; First Vein Treated	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
36483	Endovenous Ablation Therapy Of Incompetent Vein Extremity By Transcatheter Delivery Of A Chemical Adhesive (Eg Cyanoacrylate) Remote From The Access Site Inclusive Of All Imaging Guidance And Monitoring Percutaneous; Subsequent Vein(S) Treated In A Single Extremity Each Through Separate Access Sites (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
36511	Therapeutic Apheresis; For White Blood Cells	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

36522	Photopheresis Extracorporeal	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
36563	Insertion Of Tunneled Centrally Inserted Central Venous Access Device With Subcutaneous Pump	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
36836	Percutaneous Arteriovenous Fistula Creation Upper Extremity Single Access Of Both The Peripheral Artery And Peripheral Vein Including Fistula Maturation Procedures (Eg Transluminal Balloon Angioplasty Coil Embolization) When Performed Including All Vascular Access Imaging Guidance And Radiologic Supervision And Interpretation	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
36837	Percutaneous Arteriovenous Fistula Creation Upper Extremity Separate Access Sites Of The Peripheral Artery And Peripheral Vein Including Fistula Maturation Procedures (Eg Transluminal Balloon Angioplasty Coil Embolization) When Performed Including All Vascular Access Imaging Guidance And Radiologic Supervision And Interpretation	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
37215	Transcatheter Placement Of Intravascular Stent(S) Cervical Carotid Artery Open Or Percutaneous Including Angioplasty When Performed And Radiological Supervision And Interpretation; With Distal Embolic Protection	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
37216	Transcatheter Placement Of Intravascular Stent(S) Cervical Carotid Artery Open Or Percutaneous Including Angioplasty When Performed And Radiological Supervision And Interpretation; Without Distal Embolic Protection	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
37217	Transcatheter Placement Of Intravascular Stent(S) Intrathoracic Common Carotid Artery Or Innominate Artery By Retrograde Treatment Open Ipsilateral Cervical Carotid Artery Exposure Including Angioplasty When Performed And Radiological Supervision And Interpretation	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
37218	Transcatheter Placement Of Intravascular Stent(S) Intrathoracic Common Carotid Artery Or Innominate Artery Open Or Percutaneous Antegrade Approach Including Angioplasty When Performed And Radiological Supervision And Interpretation	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

37241	Vascular Embolization Or Occlusion Inclusive Of All Radiological Supervision And Interpretation Intraprocedural Roadmapping And Imaging Guidance Necessary To Complete The Intervention; Venous Other Than Hemorrhage (Eg Congenital Or Acquired Venous Malformations Venous And Capillary Hemangiomas Varices Varicoceles)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
37242	Vascular Embolization Or Occlusion Inclusive Of All Radiological Supervision And Interpretation Intraprocedural Roadmapping And Imaging Guidance Necessary To Complete The Intervention; Arterial Other Than Hemorrhage Or Tumor (Eg Congenital Or Acquired Arterial Malformations Arteriovenous Malformations Arteriovenous Fistulas Aneurysms Pseudoaneurysms)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
37243	Vascular Embolization Or Occlusion Inclusive Of All Radiological Supervision And Interpretation Intraprocedural Roadmapping And Imaging Guidance Necessary To Complete The Intervention; For Tumors Organ Ischemia Or Infarction	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
37244	Vascular Embolization Or Occlusion Inclusive Of All Radiological Supervision And Interpretation Intraprocedural Roadmapping And Imaging Guidance Necessary To Complete The Intervention; For Arterial Or Venous Hemorrhage Or Lymphatic Extravasation	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
37500	Vascular Endoscopy Surgical With Ligation Of Perforator Veins Subfascial (Seps)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
37501	Unlisted Vascular Endoscopy Procedure	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
37700	Ligation And Division Of Long Saphenous Vein At Saphenofemoral Junction Or Distal Interruptions	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
37718	Ligation Division And Stripping Short Saphenous Vein	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
37722	Ligation Division And Stripping Long (Greater) Saphenous Veins From Saphenofemoral Junction To Knee Or Below	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

37735	Ligation And Division And Complete Stripping Of Long Or Short Saphenous Veins With Radical Excision Of Ulcer And Skin Graft And/Or Interruption Of Communicating Veins Of Lower Leg With Excision Of Deep Fascia	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
37760	Ligation Of Perforator Veins Subfascial Radical (Linton Type) Including Skin Graft When Performed Open 1 Leg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
37761	Ligation Of Perforator Vein(S) Subfascial Open Including Ultrasound Guidance When Performed 1 Leg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
37765	Stab Phlebectomy Of Varicose Veins 1 Extremity; 10-20 Stab Incisions	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
37766	Stab Phlebectomy Of Varicose Veins 1 Extremity; More Than 20 Incisions	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
37780	Ligation And Division Of Short Saphenous Vein At Saphenopopliteal Junction (Separate Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
37785	Ligation Division And/Or Excision Of Varicose Vein Cluster(S) 1 Leg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
37788	Penile Revascularization Artery With Or Without Vein Graft	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
37790	Penile Venous Occlusive Procedure	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

37799	Unlisted Procedure Vascular Surgery	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
38129	Unlisted Laparoscopy Procedure Spleen	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
38204	Management Of Recipient Hematopoietic Progenitor Cell Donor Search And Cell Acquisition	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
38205	Blood-Derived Hematopoietic Progenitor Cell Harvesting For Transplantation Per Collection; Allogeneic	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
38206	Blood-Derived Hematopoietic Progenitor Cell Harvesting For Transplantation Per Collection; Autologous	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
38207	Transplant Preparation Of Hematopoietic Progenitor Cells; Cryopreservation And Storage	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
38208	Transplant Preparation Of Hematopoietic Progenitor Cells; Thawing Of Previously Frozen Harvest Without Washing Per Donor	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
38209	Transplant Preparation Of Hematopoietic Progenitor Cells; Thawing Of Previously Frozen Harvest With Washing Per Donor	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
38210	Transplant Preparation Of Hematopoietic Progenitor Cells; Specific Cell Depletion Within Harvest T-Cell Depletion	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
38211	Transplant Preparation Of Hematopoietic Progenitor Cells; Tumor Cell Depletion	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

38212	Transplant Preparation Of Hematopoietic Progenitor Cells; Red Blood Cell Removal	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
38213	Transplant Preparation Of Hematopoietic Progenitor Cells; Platelet Depletion	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
38214	Transplant Preparation Of Hematopoietic Progenitor Cells; Plasma (Volume) Depletion	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
38215	Transplant Preparation Of Hematopoietic Progenitor Cells; Cell Concentration In Plasma Mononuclear Or Buffy Coat Layer	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
38230	Bone Marrow Harvesting For Transplantation; Allogeneic	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
38232	Bone Marrow Harvesting For Transplantation; Autologous	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
38240	Hematopoietic Progenitor Cell (Hpc); Allogeneic Transplantation Per Donor	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
38241	Hematopoietic Progenitor Cell (Hpc); Autologous Transplantation	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
38242	Allogeneic Lymphocyte Infusions	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

38243	Hematopoietic Progenitor Cell (Hpc); Hpc Boost	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
38308	Lymphangiotomy Or Other Operations On Lymphatic Channels	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
38589	Unlisted Laparoscopy Procedure Lymphatic System	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
38999	Unlisted Procedure Hemic Or Lymphatic System	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
39499	Unlisted Procedure Mediastinum	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
39599	Unlisted Procedure Diaphragm	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
40799	Unlisted Procedure Lips	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
40899	Unlisted Procedure Vestibule Of Mouth	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
41120	Glossectomy; Less Than One-Half Tongue	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
41512	Tongue Base Suspension Permanent Suture Technique	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
41530	Submucosal Ablation Of The Tongue Base Radiofrequency 1 Or More Sites 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).	_	3/31/2024	Retire effective 03/31/2024
41530	Submucosal Ablation Of The Tongue Base Radiofrequency 1 Or More Sites Per Session	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2024	_	Add effectuce 04/01/2024

41599	Unlisted Procedure Tongue Floor Of Mouth	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
41872	Gingivoplasty Each Quadrant (Specify)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	2/1/2024	_	Add effective 02/01/2024
41899	Unlisted Procedure Dentoalveolar Structures	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
42140	Uvulectomy Excision Of Uvula	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
42145	Palatopharyngoplasty (Eg Uvulopalatopharyngoplasty Uvulopharyngoplasty)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
42299	Unlisted Procedure Palate Uvula	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
42699	Unlisted Procedure Salivary Glands Or Ducts	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
42950	Pharyngoplasty (Plastic Or Reconstructive Operation On Pharynx)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	3/15/2024	_	Add effectuce 03/15/2024
42999	Unlisted Procedure Pharynx Adenoids Or Tonsils	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
43192	Esophagoscopy Rigid Transoral; With Directed Submucosal Injection(S) Any Substance	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43201	Esophagoscopy Flexible Transoral; With Directed Submucosal Injection(S) Any Substance	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43206	Esophagoscopy Flexible Transoral; With Optical Endomicroscopy	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_

43210	Esophagogastroduodenoscopy Flexible Transoral; With Esophagogastric Fundoplasty Partial Or Complete Includes Duodenoscopy When Performed	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43236	Esophagogastroduodenoscopy Flexible Transoral; With Directed Submucosal Injection(S) Any Substance	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43252	Esophagogastroduodenoscopy Flexible Transoral; With Optical Endomicroscopy	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
43253	Esophagogastroduodenoscopy Flexible Transoral; With Transendoscopic Ultrasound-Guided Transmural Injection Of Diagnostic Or Therapeutic Substance(S) (Eg Anesthetic Neurolytic Agent) Or Fiducial Marker(S) (Includes Endoscopic Ultrasound Examination Of The Esophagus Stomach And Either The Duodenum Or A Surgically Altered Stomach Where The Jejunum Is Examined Distal To The Anastomosis)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43257	Esophagogastroduodenoscopy Flexible Transoral; With Delivery Of Thermal Energy To The Muscle Of Lower Esophageal Sphincter And/Or Gastric Cardia For Treatment Of Gastroesophageal Reflux Disease	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43284	Laparoscopy Surgical Esophageal Sphincter Augmentation Procedure Placement Of Sphincter Augmentation Device (Ie Magnetic Band) Including Cruroplasty When Performed	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43285	Removal Of Esophageal Sphincter Augmentation Device	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43289	Unlisted Laparoscopy Procedure Esophagus	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_

43290	Esophagogastroduodenoscopy Flexible Transoral; With Deployment Of Intragastric Bariatric Balloon	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
43291	Esophagogastroduodenoscopy Flexible Transoral; With Removal Of Intragastric Bariatric Balloon(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).	_	_	_
43312	Esophagoplasty (Plastic Repair Or Reconstruction) Thoracic Approach; With Repair Of Tracheoesophageal Fistula	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43499	Unlisted Procedure Esophagus	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
43632	Gastrectomy Partial Distal; With Gastrojejunostomy	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43633	Gastrectomy Partial Distal; With Roux-En-Y Reconstruction	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43644	Laparoscopy Surgical Gastric Restrictive Procedure; With Gastric Bypass And Roux-En-Y Gastroenterostomy (Roux Limb 150 Cm Or Less)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43645	Laparoscopy Surgical Gastric Restrictive Procedure; With Gastric Bypass And Small Intestine Reconstruction To Limit Absorption	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43659	Unlisted Laparoscopy Procedure Stomach	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
43770	Laparoscopy Surgical Gastric Restrictive Procedure; Placement Of Adjustable Gastric Restrictive Device (Eg Gastric Band And Subcutaneous Port Components)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

43771	Laparoscopy Surgical Gastric Restrictive Procedure; Revision Of Adjustable Gastric Restrictive Device Component Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43772	Laparoscopy Surgical Gastric Restrictive Procedure; Removal Of Adjustable Gastric Restrictive Device Component Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43773	Laparoscopy Surgical Gastric Restrictive Procedure; Removal And Replacement Of Adjustable Gastric Restrictive Device Component Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43774	Laparoscopy Surgical Gastric Restrictive Procedure; Removal Of Adjustable Gastric Restrictive Device And Subcutaneous Port Components	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43775	Laparoscopy Surgical Gastric Restrictive Procedure; Longitudinal Gastrectomy (Ie Sleeve Gastrectomy)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43842	Gastric Restrictive Procedure Without Gastric Bypass For Morbid Obesity; Vertical-Banded Gastroplasty	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43843	Gastric Restrictive Procedure Without Gastric Bypass For Morbid Obesity; Other Than Vertical-Banded Gastroplasty	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43845	Gastric Restrictive Procedure With Partial Gastrectomy Pylorus-Preserving Duodenoileostomy And Ileoileostomy (50 To 100 Cm Common Channel) To Limit Absorption (Biliopancreatic Diversion With Duodenal Switch)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43846	Gastric Restrictive Procedure With Gastric Bypass For Morbid Obesity; With Short Limb (150 Cm Or Less) Roux-En-Y Gastroenterostomy	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

43847	Gastric Restrictive Procedure With Gastric Bypass For Morbid Obesity; With Small Intestine Reconstruction To Limit Absorption	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43848	Revision Open Of Gastric Restrictive Procedure For Morbid Obesity Other Than Adjustable Gastric Restrictive Device (Separate Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43860	Revision Of Gastrojejunal Anastomosis (Gastrojejunostomy) With Reconstruction With Or Without Partial Gastrectomy Or Intestine Resection; Without Vagotomy	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43886	Gastric Restrictive Procedure Open; Revision Of Subcutaneous Port Component Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43887	Gastric Restrictive Procedure Open; Removal Of Subcutaneous Port Component Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43888	Gastric Restrictive Procedure Open; Removal And Replacement Of Subcutaneous Port Component Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
43999	Unlisted Procedure Stomach	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
44238	Unlisted Laparoscopy Procedure Intestine (Except Rectum)	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
44640	Closure Of Intestinal Cutaneous Fistula	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
44705	Preparation Of Fecal Microbiota For Instillation Including Assessment Of Donor Specimen	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

44799	Unlisted Procedure Small Intestine	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
44899	Unlisted Procedure Meckel'S Diverticulum And The Mesentery	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
44979	Unlisted Laparoscopy Procedure Appendix	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
45399	Unlisted Procedure Colon	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
45499	Unlisted Laparoscopy Procedure Rectum	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
45999	Unlisted Procedure Rectum	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
46707	Repair Of Anorectal Fistula With Plug (Eg Porcine Small Intestine Submucosa [Sis])	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
46999	Unlisted Procedure Anus	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
47370	Laparoscopy Surgical Ablation Of 1 Or More Liver Tumor(S); Radiofrequency	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
47379	Unlisted Laparoscopic Procedure Liver	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
47380	Ablation Open Of 1 Or More Liver Tumor(S); Radiofrequency	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
47381	Ablation Open Of 1 Or More Liver Tumor(S); Cryosurgical	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

47382	Ablation 1 Or More Liver Tumor(S) Percutaneous Radiofrequency	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
47399	Unlisted Procedure Liver	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
47579	Unlisted Laparoscopy Procedure Biliary Tract	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
47999	Unlisted Procedure Biliary Tract	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
48999	Unlisted Procedure Pancreas	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
49329	Unlisted Laparoscopy Procedure Abdomen Peritoneum And Omentum	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
49411	Placement Of Interstitial Device(S) For Radiation Therapy Guidance (Eg Fiducial Markers Dosimeter) Percutaneous Intra-Abdominal Intra-Pelvic (Except Prostate) And/Or Retroperitoneum Single Or Multiple	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
49412	Placement Of Interstitial Device(S) For Radiation Therapy Guidance (Eg Fiducial Markers Dosimeter) Open Intra-Abdominal Intrapelvic And/Or Retroperitoneum Including Image Guidance If Performed Single Or Multiple (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
49659	Unlisted Laparoscopy Procedure Hernioplasty Herniorrhaphy Herniotomy	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
49999	Unlisted Procedure Abdomen Peritoneum And Omentum	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
50250	Ablation Open 1 Or More Renal Mass Lesion(S) Cryosurgical Including Intraoperative Ultrasound Guidance And Monitoring If Performed	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
50360	Renal Allotransplantation Implantation Of Graft; Without Recipient Nephrectomy	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

50541	Laparoscopy Surgical; Ablation Of Renal Cysts	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
50542	Laparoscopy Surgical; Ablation Of Renal Mass Lesion(S) Including Intraoperative Ultrasound Guidance And Monitoring When Performed	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
50549	Unlisted Laparoscopy Procedure Renal	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
50592	Ablation 1 Or More Renal Tumor(S) Percutaneous Unilateral Radiofrequency	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
50593	Ablation Renal Tumor(S) Unilateral Percutaneous Cryotherapy	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
50949	Unlisted Laparoscopy Procedure Ureter	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
51715	Endoscopic Injection Of Implant Material Into The Submucosal Tissues Of The Urethra And/Or Bladder Neck	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
51999	Unlisted Laparoscopy Procedure Bladder	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
52284	Cystourethroscopy With Mechanical Urethral Dilation And Urethral Therapeutic Drug Delivery By Drug-Coated Balloon Catheter For Urethral Stricture Or Stenosis Male Including Fluoroscopy When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	5/14/2024	Retire effective 05/14/2024
52284	Cystourethroscopy With Mechanical Urethral Dilation And Urethral Therapeutic Drug Delivery By Drug-Coated Balloon Catheter For Urethral Stricture Or Stenosis Male Including Fluoroscopy When Performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024
52287	Cystourethroscopy With Injection(S) For Chemodenervation Of The Bladder	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

52327	Cystourethroscopy (Including Ureteral Catheterization); With Subureteric Injection Of Implant Material	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
52441	Cystourethroscopy With Insertion Of Permanent Adjustable Transprostatic Implant; Single Implant	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
52442	Cystourethroscopy With Insertion Of Permanent Adjustable Transprostatic Implant; Each Additional Permanent Adjustable Transprostatic Implant (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
53451	Periurethral Transperineal Adjustable Balloon Continence Device; Bilateral Insertion Including Cystourethroscopy And Imaging Guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	5/1/2024	_	Add effective 5/1/2024
53452	Periurethral Transperineal Adjustable Balloon Continence Device; Unilateral Insertion Including Cystourethroscopy And Imaging Guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	5/1/2024	_	Add effective 5/1/2024
53453	Periurethral Transperineal Adjustable Balloon Continence Device; Removal Each Balloon	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	5/1/2024	_	Add effective 5/1/2024
53454	Periurethral Transperineal Adjustable Balloon Continence Device; Percutaneous Adjustment Of Balloon(S) Fluid Volume	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	5/1/2024	_	Add effective 5/1/2024
53855	Insertion Of A Temporary Prostatic Urethral Stent Including Urethral Measurement	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	5/14/2024	retire effective 05/14/2024
53855	Insertion Of A Temporary Prostatic Urethral Stent Including Urethral Measurement	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024
53860	Transurethral Radiofrequency Micro-Remodeling Of The Female Bladder Neck And Proximal Urethra For Stress Urinary Incontinence	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
53899	Unlisted Procedure Urinary System	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
54110	Excision Of Penile Plaque (Peyronie Disease);	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

54111	Excision Of Penile Plaque (Peyronie Disease); With Graft To 5 Cm In Length	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
54112	Excision Of Penile Plaque (Peyronie Disease); With Graft Greater Than 5 Cm In Length	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
54125	Amputation Of Penis; Complete	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
54200	Injection Procedure For Peyronie Disease;	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
54205	Injection Procedure For Peyronie Disease; With Surgical Exposure Of Plaque	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
54235	Injection Of Corpora Cavernosa With Pharmacologic Agent(S) (Eg Papaverine Phentolamine)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
54240	Penile Plethysmography	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
54360	Plastic Operation On Penis To Correct Angulation	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
54400	Insertion Of Penile Prosthesis; Non-Inflatable (Semi-Rigid)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

54401	Insertion Of Penile Prosthesis; Inflatable (Self-Contained)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
54405	Insertion Of Multi-Component Inflatable Penile Prosthesis Including Placement Of Pump Cylinders And Reservoir	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
54406	Removal Of All Components Of A Multi-Component Inflatable Penile Prosthesis Without Replacement Of Prosthesis	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
54408	Repair Of Component(S) Of A Multi-Component Inflatable Penile Prosthesis	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
54410	Removal And Replacement Of All Component(S) Of A Multi-Component Inflatable Penile Prosthesis At The Same Operative Session	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
54411	Removal And Replacement Of All Components Of A Multi-Component Inflatable Penile Prosthesis Through An Infected Field At The Same Operative Session Including Irrigation And Debridement Of Infected Tissue	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
54415	Removal Of Non-Inflatable (Semi-Rigid) Or Inflatable (Self-Contained) Penile Prosthesis Without Replacement Of Prosthesis	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
54416	Removal And Replacement Of Non-Inflatable (Semi-Rigid) Or Inflatable (Self-Contained) Penile Prosthesis At The Same Operative Session	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
54417	Removal And Replacement Of Non-Inflatable (Semi-Rigid) Or Inflatable (Self-Contained) Penile Prosthesis Through An Infected Field At The Same Operative Session Including Irrigation And Debridement Of Infected Tissue	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
54440	Plastic Operation Of Penis For Injury	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_

54660	Insertion Of Testicular Prosthesis (Separate Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
54699	Unlisted Laparoscopy Procedure Testis	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
55400	Vasovasostomy Vasovasorrhaphy	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
55559	Unlisted Laparoscopy Procedure Spermatic Cord	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
55706	Biopsies Prostate Needle Transperineal Stereotactic Template Guided Saturation Sampling Including Imaging Guidance	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
55870	Electroejaculation	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
55873	Cryosurgical Ablation Of The Prostate (Includes Ultrasonic Guidance And Monitoring)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
55880	Ablation Of Malignant Prostate Tissue Transrectal With High Intensity-Focused Ultrasound (Hifu) Including Ultrasound Guidance	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
55899	Unlisted Procedure Male Genital System	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
55970	Intersex Surgery; Male To Female	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
55980	Intersex Surgery; Female To Male	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

56805	Clitoroplasty For Intersex State	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
56810	Perineoplasty Repair Of Perineum Nonobstetrical (Separate Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
57291	Construction Of Artificial Vagina; Without Graft	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
57292	Construction Of Artificial Vagina; With Graft	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
57295	Revision (Including Removal) Of Prosthetic Vaginal Graft; Vaginal Approach	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
57296	Revision (Including Removal) Of Prosthetic Vaginal Graft; Open Abdominal Approach	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
57307	Closure Of Rectovaginal Fistula; Abdominal Approach With Concomitant Colostomy	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
57335	Vaginoplasty For Intersex State	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
57426	Revision (Including Removal) Of Prosthetic Vaginal Graft Laparoscopic Approach	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
58321	Artificial Insemination; Intra-Cervical	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_

58322	Artificial Insemination; Intra-Uterine	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
58323	Sperm Washing For Artificial Insemination	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
58578	Unlisted Laparoscopy Procedure Uterus	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
58579	Unlisted Hysteroscopy Procedure Uterus	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
58580	Transcervical Ablation Of Uterine Fibroid(S) Including Intraoperative Ultrasound Guidance And Monitoring Radiofrequency	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
58674	Laparoscopy Surgical Ablation Of Uterine Fibroid(S) Including Intraoperative Ultrasound Guidance And Monitoring Radiofrequency	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
58679	Unlisted Laparoscopy Procedure Oviduct Ovary	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
58750	Tubotubal Anastomosis	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
58752	Tubouterine Implantation	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
58970	Follicle Puncture For Oocyte Retrieval Any Method	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
58974	Embryo Transfer Intrauterine	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
58976	Gamete Zygote Or Embryo Intrafallopian Transfer Any Method	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
58999	Unlisted Procedure Female Genital System (Nonobstetrical)	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
59072	Fetal Umbilical Cord Occlusion Including Ultrasound Guidance	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
59074	Fetal Fluid Drainage (Eg Vesicocentesis Thoracocentesis Paracentesis) Including Ultrasound Guidance	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
59076	Fetal Shunt Placement Including Ultrasound Guidance	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

59897	Unlisted Fetal Invasive Procedure Including Ultrasound Guidance When Performed	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
59898	Unlisted Laparoscopy Procedure Maternity Care And Delivery	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
59899	Unlisted Procedure Maternity Care And Delivery	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
60659	Unlisted Laparoscopy Procedure Endocrine System	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
60699	Unlisted Procedure Endocrine System	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
61215	Insertion Of Subcutaneous Reservoir Pump Or Continuous Infusion System For Connection To Ventricular Catheter	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
61630	Balloon Angioplasty Intracranial (Eg Atherosclerotic Stenosis) Percutaneous	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
61635	Transcatheter Placement Of Intravascular Stent(S) Intracranial (Eg Atherosclerotic Stenosis) Including Balloon Angioplasty If Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	2/1/2024	_	Add effective 02/01/2024
61645	Percutaneous Arterial Transluminal Mechanical Thrombectomy And/Or Infusion For Thrombolysis Intracranial Any Method Including Diagnostic Angiography Fluoroscopic Guidance Catheter Placement And Intraprocedural Pharmacological Thrombolytic Injection(S)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

61650	Endovascular Intracranial Prolonged Administration Of Pharmacologic Agent(S) Other Than For Thrombolysis Arterial Including Catheter Placement Diagnostic Angiography And Imaging Guidance; Initial Vascular Territory	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
61651	Endovascular Intracranial Prolonged Administration Of Pharmacologic Agent(S) Other Than For Thrombolysis Arterial Including Catheter Placement Diagnostic Angiography And Imaging Guidance; Each Additional Vascular Territory (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
61736	Laser Interstitial Thermal Therapy (Litt) Of Lesion Intracranial Including Burr Hole(S) With Magnetic Resonance Imaging Guidance When Performed; Single Trajectory For 1 Simple Lesion	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
61737	Laser Interstitial Thermal Therapy (Litt) Of Lesion Intracranial Including Burr Hole(S) With Magnetic Resonance Imaging Guidance When Performed; Multiple Trajectories For Multiple Or Complex Lesion(S)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
61783	Stereotactic Computer-Assisted (Navigational) Procedure; Spinal (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	5/15/2024	6/30/2024	Add effective 05/15/2024 Retire effective 06/30/2024
61783	Stereotactic Computer-Assisted (Navigational) Procedure; Spinal (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
61889	Insertion Of Skull-Mounted Cranial Neurostimulator Pulse Generator Or Receiver Including Craniectomy Or Craniotomy When Performed With Direct Or Inductive Coupling With Connection To Depth And/Or Cortical Strip Electrode Array(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
61891	Revision Or Replacement Of Skull-Mounted Cranial Neurostimulator Pulse Generator Or Receiver With Connection To Depth And/Or Cortical Strip Electrode Array(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
61892	Removal Of Skull-Mounted Cranial Neurostimulator Pulse Generator Or Receiver With Cranioplasty When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
62263	Percutaneous Lysis Of Epidural Adhesions Using Solution Injection (Eg Hypertonic Saline Enzyme) Or Mechanical Means (Eg Catheter) Including Radiologic Localization (Includes Contrast When Administered) Multiple Adhesiolysis Sessions; 2 Or More 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).	_	_	_

62264	Percutaneous Lysis Of Epidural Adhesions Using Solution Injection (Eg Hypertonic Saline Enzyme) Or Mechanical Means (Eg Catheter) Including Radiologic Localization (Includes Contrast When Administered) Multiple Adhesiolysis Sessions; 1 Day	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
62287	Decompression Procedure Percutaneous Of Nucleus Pulposus Of Intervertebral Disc Any Method Utilizing Needle Based Technique To Remove Disc Material Under Fluoroscopic Imaging Or Other Form Of Indirect Visualization With Discography And/Or Epidural Injection(S) At The Treated Level(S) When Performed Single Or Multiple Levels Lumbar	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
64505	Injection Anesthetic Agent; Sphenopalatine Ganglion	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
64555	Percutaneous Implantation Of Neurostimulator Electrode Array; Peripheral Nerve (Excludes Sacral Nerve)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
64566	Posterior Tibial Neurostimulation Percutaneous Needle Electrode Single Treatment Includes Programming	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
64568	Open Implantation Of Cranial Nerve (Eg Vagus Nerve) Neurostimulator Electrode Array And Pulse Generator	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
64575	Open Implantation Of Neurostimulator Electrode Array; Peripheral Nerve (Excludes Sacral Nerve)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
64582	Open Implantation Of Hypoglossal Nerve Neurostimulator Array Pulse Generator And Distal Respiratory Sensor Electrode Or Electrode Array	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
64583	Revision Or Replacement Of Hypoglossal Nerve Neurostimulator Array And Distal Respiratory Sensor Electrode Or Electrode Array Including Connection To Existing Pulse Generator	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

64584	Removal Of Hypoglossal Nerve Neurostimulator Array Pulse Generator And Distal Respiratory Sensor Electrode Or Electrode Array	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
64590	Insertion Or Replacement Of Peripheral Sacral Or Gastric Neurostimulator Pulse Generator Or Receiver Requiring Pocket Creation And Connection Between Electrode Array And Pulse Generator Or Receiver	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
64596	Insertion Or Replacement Of Percutaneous Electrode Array Peripheral Nerve With Integrated Neurostimulator Including Imaging Guidance When Performed; Initial Electrode Array	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
64597	Insertion Or Replacement Of Percutaneous Electrode Array Peripheral Nerve With Integrated Neurostimulator Including Imaging Guidance When Performed; Each Additional Electrode Array (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
64598	Revision Or Removal Of Neurostimulator Electrode Array Peripheral Nerve With Integrated Neurostimulator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
64615	Chemodenervation Of Muscle(S); Muscle(S) Innervated By Facial Trigeminal Cervical Spinal And Accessory Nerves Bilateral (Eg For Chronic Migraine)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
64624	Destruction By Neurolytic Agent Genicular Nerve Branches Including Imaging Guidance When Performed	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
64628	Thermal Destruction Of Intraosseous Basivertebral Nerve Including All Imaging Guidance; First 2 Vertebral Bodies Lumbar Or Sacral	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
64629	Thermal Destruction Of Intraosseous Basivertebral Nerve Including All Imaging Guidance; Each Additional Vertebral Body Lumbar Or Sacral (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
64640	Destruction By Neurolytic Agent; Other Peripheral Nerve Or Branch	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

64650	Chemodenervation Of Eccrine Glands; Both Axillae	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
64653	Chemodenervation Of Eccrine Glands; Other Area(S) (Eg Scalp Face Neck) Per Day	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
64802	Sympathectomy Cervical	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
64804	Sympathectomy Cervicothoracic	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
64809	Sympathectomy Thoracolumbar	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
64818	Sympathectomy Lumbar	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
64820	Sympathectomy; Digital Arteries Each Digit	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
64823	Sympathectomy; Superficial Palmar Arch	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
64999	Unlisted Procedure Nervous System	Unlisted Procedure; May require Prior Authorization per contract agreement.	_	_	_

65710	Keratoplasty (Corneal Transplant); Anterior Lamellar	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
65730	Keratoplasty (Corneal Transplant); Penetrating (Except In Aphakia Or Pseudophakia)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
65750	Keratoplasty (Corneal Transplant); Penetrating (In Aphakia)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
65755	Keratoplasty (Corneal Transplant); Penetrating (In Pseudophakia)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
65756	Keratoplasty (Corneal Transplant); Endothelial	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
65757	Backbench Preparation Of Corneal Endothelial Allograft Prior To Transplantation (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
65760	Keratomileusis	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
65765	Keratophakia	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
65767	Epikeratoplasty	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
65770	Keratoprosthesis	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
65771	Radial Keratotomy	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_

65772	Corneal Relaxing Incision For Correction Of Surgically Induced Astigmatism	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
65775	Corneal Wedge Resection For Correction Of Surgically Induced Astigmatism	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
65778	Placement Of Amniotic Membrane On The Ocular Surface; Without Sutures	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
65785	Implantation Of Intrastromal Corneal Ring Segments	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
66174	Transluminal Dilation Of Aqueous Outflow Canal (Eg Canaloplasty); Without Retention Of Device Or Stent	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
66175	Transluminal Dilation Of Aqueous Outflow Canal (Eg Canaloplasty); With Retention Of Device Or Stent	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
66179	Aqueous Shunt To Extraocular Equatorial Plate Reservoir External Approach; Without Graft	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
66180	Aqueous Shunt To Extraocular Equatorial Plate Reservoir External Approach; With Graft	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
66183	Insertion Of Anterior Segment Aqueous Drainage Device Without Extraocular Reservoir External Approach	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

66184	Revision Of Aqueous Shunt To Extraocular Equatorial Plate Reservoir; Without Graft	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
66185	Revision Of Aqueous Shunt To Extraocular Equatorial Plate Reservoir; With Graft	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
66989	Extracapsular Cataract Removal With Insertion Of Intraocular Lens Prosthesis (1-Stage Procedure) Manual Or Mechanical Technique (Eg Irrigation And Aspiration Or Phacoemulsification) Complex Requiring Devices Or Techniques Not Generally Used In Routine Cataract Surgery (Eg Iris Expansion Device Suture Support For Intraocular Lens Or Primary Posterior Capsulorrhexis) Or Performed On Patients In The Amblyogenic Developmental Stage; With Insertion Of Intraocular (Eg Trabecular Meshwork Supraciliary Suprachoroidal) Anterior Segment Aqueous Drainage Device Without Extraocular Reservoir Internal Approach One Or More	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
66991	Extracapsular Cataract Removal With Insertion Of Intraocular Lens Prosthesis (1 Stage Procedure) Manual Or Mechanical Technique (Eg Irrigation And Aspiration Or Phacoemulsification); With Insertion Of Intraocular (Eg Trabecular Meshwork Supraciliary Suprachoroidal) Anterior Segment Aqueous Drainage Device Without Extraocular Reservoir Internal Approach One Or More	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
66999	Unlisted Procedure Anterior Segment Of Eye	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
67027	Implantation Of Intravitreal Drug Delivery System (Eg Ganciclovir Implant) Includes Concomitant Removal Of Vitreous	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
67028	Intravitreal Injection Of A Pharmacologic Agent (Separate Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
67221	Destruction Of Localized Lesion Of Choroid (Eg Choroidal Neovascularization); Photodynamic Therapy (Includes Intravenous Infusion)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

67225	Destruction Of Localized Lesion Of Choroid (Eg Choroidal Neovascularization); Photodynamic Therapy Second Eye At Single Session (List Separately In Addition To Code For Primary Eye Treatment)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
67299	Unlisted Procedure Posterior Segment	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
67399	Unlisted Procedure Extraocular Muscle	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
67516	Suprachoroidal Space Injection Of Pharmacologic Agent (Separate Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	2/15/2024	_	Add effectuce 02/15/2024
67599	Unlisted Procedure Orbit	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
67901	Repair Of Blepharoptosis; Frontalis Muscle Technique With Suture Or Other Material (Eg Banked Fascia)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
67902	Repair Of Blepharoptosis; Frontalis Muscle Technique With Autologous Fascial Sling (Includes Obtaining Fascia)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
67903	Repair Of Blepharoptosis; (Tarso) Levator Resection Or Advancement Internal Approach	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
67904	Repair Of Blepharoptosis; (Tarso) Levator Resection Or Advancement External Approach	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
67906	Repair Of Blepharoptosis; Superior Rectus Technique With Fascial Sling (Includes Obtaining Fascia)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
67908	Repair Of Blepharoptosis; Conjunctivo-Tarso-Muller'S Muscle-Levator Resection (Eg Fasanella-Servat Type)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

67999	Unlisted Procedure Eyelids	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
68399	Unlisted Procedure Conjunctiva	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
68899	Unlisted Procedure Lacrimal System	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
69090	Ear Piercing	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
69300	Otoplasty Protruding Ear With Or Without Size Reduction	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
69399	Unlisted Procedure External Ear	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
69676	Tympanic Neurectomy	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
69705	Nasopharyngoscopy Surgical With Dilation Of Eustachian Tube (Ie Balloon Dilation); Unilateral	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
69706	Nasopharyngoscopy Surgical With Dilation Of Eustachian Tube (Ie Balloon Dilation); Bilateral	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
69716	Implantation Osseointegrated Implant Skull; With Magnetic Transcutaneous Attachment To External Speech Processor Within The Mastoid And/Or Resulting In Removal Of Less Than 100 Sq Mm Surface Area Of Bone Deep To The Outer Cranial Cortex	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

69719	Replacement (Including Removal Of Existing Device) Osseointegrated Implant Skull; With Magnetic Transcutaneous Attachment To External Speech Processor Within The Mastoid And/Or Involving A Bony Defect Less Than 100 Sq Mm Surface Area Of Bone Deep To The Outer Cranial Cortex	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
69728	Removal Entire Osseointegrated Implant Skull; With Magnetic Transcutaneous Attachment To External Speech Processor Outside The Mastoid And Involving A Bony Defect Greater Than Or Equal To 100 Sq Mm Surface Area Of Bone Deep To The Outer Cranial Cortex	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
69729	Implantation Osseointegrated Implant Skull; With Magnetic Transcutaneous Attachment To External Speech Processor Outside Of The Mastoid And Resulting In Removal Of Greater Than Or Equal To 100 Sq Mm Surface Area Of Bone Deep To The Outer Cranial Cortex	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
69730	Replacement (Including Removal Of Existing Device) Osseointegrated Implant Skull; With Magnetic Transcutaneous Attachment To External Speech Processor Outside The Mastoid And Involving A Bony Defect Greater Than Or Equal To 100 Sq Mm Surface Area Of Bone Deep To The Outer Cranial Cortex	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
69799	Unlisted Procedure Middle Ear	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
69949	Unlisted Procedure Inner Ear	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
69979	Unlisted Procedure Temporal Bone Middle Fossa Approach	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
75580	Noninvasive Estimate Of Coronary Fractional Flow Reserve (Ffr) Derived From Augmentative Software Analysis Of The Data Set From A Coronary Computed Tomography Angiography With Interpretation And Report By A Physician Or Other Qualified Health Care Professional	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
75894	Transcatheter Therapy Embolization Any Method Radiological Supervision And Interpretation	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

75956	Endovascular Repair Of Descending Thoracic Aorta (Eg Aneurysm Pseudoaneurysm Dissection Penetrating Ulcer Intramural Hematoma Or Traumatic Disruption); Involving Coverage Of Left Subclavian Artery Origin Initial Endoprosthesis Plus Descending Thoracic Aortic Extension(S) If Required To Level Of Celiac Artery Origin Radiological Supervision And Interpretation	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
75957	Endovascular Repair Of Descending Thoracic Aorta (Eg Aneurysm Pseudoaneurysm Dissection Penetrating Ulcer Intramural Hematoma Or Traumatic Disruption); Not Involving Coverage Of Left Subclavian Artery Origin Initial Endoprosthesis Plus Descending Thoracic Aortic Extension(S) If Required To Level Of Celiac Artery Origin Radiological Supervision And Interpretation	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
75958	Placement Of Proximal Extension Prosthesis For Endovascular Repair Of Descending Thoracic Aorta (Eg Aneurysm Pseudoaneurysm Dissection Penetrating Ulcer Intramural Hematoma Or Traumatic Disruption) Radiological Supervision And Interpretation	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
75959	Placement Of Distal Extension Prosthesis(S) (Delayed) After Endovascular Repair Of Descending Thoracic Aorta As Needed To Level Of Celiac Origin Radiological Supervision And Interpretation	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
76120	Cineradiography/Videoradiography Except Where Specifically Included	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
76125	Cineradiography/Videoradiography To Complement Routine Examination (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
76496	Unlisted Fluoroscopic Procedure (Eg Diagnostic Interventional)	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
76497	Unlisted Computed Tomography Procedure (Eg Diagnostic Interventional)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_

76498	Unlisted Magnetic Resonance Procedure (Eg Diagnostic Interventional)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
76499	Unlisted Diagnostic Radiographic Procedure	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
76940	Ultrasound Guidance For And Monitoring Of Parenchymal Tissue Ablation	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
76948	Ultrasonic Guidance For Aspiration Of Ova Imaging Supervision And Interpretation	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
76999	Unlisted Ultrasound Procedure (Eg Diagnostic Interventional)	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
77013	Computed Tomography Guidance For And Monitoring Of Parenchymal Tissue Ablation	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
77299	Unlisted Procedure Therapeutic Radiology Clinical Treatment Planning	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
77399	Unlisted Procedure Medical Radiation Physics Dosimetry And Treatment Devices And Special Services	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_

77499	Unlisted Procedure Therapeutic Radiology Treatment Management	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
77799	Unlisted Procedure Clinical Brachytherapy	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
78099	Unlisted Endocrine Procedure Diagnostic Nuclear Medicine	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
78199	Unlisted Hematopoietic Reticuloendothelial And Lymphatic Procedure Diagnostic Nuclear Medicine	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
78299	Unlisted Gastrointestinal Procedure Diagnostic Nuclear Medicine	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
78399	Unlisted Musculoskeletal Procedure Diagnostic Nuclear Medicine	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
78434	Absolute Quantitation Of Myocardial Blood Flow (Aqmbf) Positron Emission Tomography (Pet) Rest And Pharmacologic Stress (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
78499	Unlisted Cardiovascular Procedure Diagnostic Nuclear Medicine	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
78599	Unlisted Respiratory Procedure Diagnostic Nuclear Medicine	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
78699	Unlisted Nervous System Procedure Diagnostic Nuclear Medicine	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
78799	Unlisted Genitourinary Procedure Diagnostic Nuclear Medicine	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_

78999	Unlisted Miscellaneous Procedure Diagnostic Nuclear Medicine	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
79445	Radiopharmaceutical Therapy By Intra-Arterial Particulate Administration	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
79999	Radiopharmaceutical Therapy Unlisted Procedure	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
80299	Quantitation Of Therapeutic Drug Not Elsewhere Specified	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
81099	Unlisted Urinalysis Procedure	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
81161	Dmd (Dystrophin) (Eg Duchenne/Becker Muscular Dystrophy) Deletion Analysis And Duplication Analysis If Performed	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
81206	Bcr/Abl1 (T(9;22)) (Eg Chronic Myelogenous Leukemia) Translocation Analysis; Major Breakpoint Qualitative Or Quantitative	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
81207	Bcr/Abl1 (T(9;22)) (Eg Chronic Myelogenous Leukemia) Translocation Analysis; Minor Breakpoint Qualitative Or Quantitative	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
81241	F5 (Coagulation Factor V) (Eg Hereditary Hypercoagulability) Gene Analysis Leiden Variant	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
81243	Fmr1 (Fragile X Messenger Ribonucleoprotein 1) (Eg Fragile X Syndrome X-Linked Intellectual Disability [Xlid]) Gene Analysis; Evaluation To Detect Abnormal (Eg Expanded) Alleles	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
81420	Fetal Chromosomal Aneuploidy (Eg Trisomy 21 Monosomy X) Genomic Sequence Analysis Panel Circulating Cell-Free Fetal Dna In Maternal Blood Must Include Analysis Of Chromosomes 13 18 And 21	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

81457	Solid Organ Neoplasm Genomic Sequence Analysis Panel Interrogation For Sequence Variants; Dna Analysis Microsatellite Instability	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	3/31/2024	Add effective 01/01/2024 Retire effective 03/31/2024
81458	Solid Organ Neoplasm Genomic Sequence Analysis Panel Interrogation For Sequence Variants; Dna Analysis Copy Number Variants And Microsatellite Instability	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	3/31/2024	Add effective 01/01/2024 Retire effective 03/31/2024
81459	Solid Organ Neoplasm Genomic Sequence Analysis Panel Interrogation For Sequence Variants; Dna Analysis Or Combined Dna And Rna Analysis Copy Number Variants Microsatellite Instability Tumor Mutation Burden And Rearrangements	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	3/31/2024	Add effective 01/01/2024 Retire effective 03/31/2024
81462	Solid Organ Neoplasm Genomic Sequence Analysis Panel Cell-Free Nucleic Acid (Eg Plasma) Interrogation For Sequence Variants; Dna Analysis Or Combined Dna And Rna Analysis Copy Number Variants And Rearrangements	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	3/31/2024	Add effective 01/01/2024 Retire effective 03/31/2024
81463	Solid Organ Neoplasm Genomic Sequence Analysis Panel Cell-Free Nucleic Acid (Eg Plasma) Interrogation For Sequence Variants; Dna Analysis Copy Number Variants And Microsatellite Instability	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	3/31/2024	Add effective 01/01/2024 Retire effective 03/31/2024
81464	Solid Organ Neoplasm Genomic Sequence Analysis Panel Cell-Free Nucleic Acid (Eg Plasma) Interrogation For Sequence Variants; Dna Analysis Or Combined Dna And Rna Analysis Copy Number Variants Microsatellite Instability Tumor Mutation Burden And Rearrangements	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	3/31/2024	Add effective 01/01/2024 Retire effective 03/31/2024
81479	Unlisted Molecular Pathology Procedure	Unlisted Procedure; May require Prior Authorization per contract agreement.	_	_	_
81490	Autoimmune (Rheumatoid Arthritis) Analysis Of 12 Biomarkers Using Immunoassays Utilizing Serum Prognostic Algorithm Reported As A Disease Activity Score	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
81503	Oncology (Ovarian) Biochemical Assays Of Five Proteins (Ca-125 Apolipoprotein A1 Beta-2 Microglobulin Transferrin And Pre-Albumin) Utilizing Serum Algorithm Reported As A Risk Score	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
81507	Fetal Aneuploidy (Trisomy 21 18 And 13) Dna Sequence Analysis Of Selected Regions Using Maternal Plasma Algorithm Reported As A Risk Score For Each Trisomy	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
81535	Oncology (Gynecologic) Live Tumor Cell Culture And Chemotherapeutic Response By Dapi Stain And Morphology Predictive Algorithm Reported As A Drug Response Score; First Single Drug Or Drug Combination	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

81536	Oncology (Gynecologic) Live Tumor Cell Culture And Chemotherapeutic Response By Dapi Stain And Morphology Predictive Algorithm Reported As A Drug Response Score; Each Additional Single Drug Or Drug Combination (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
81538	Oncology (Lung) Mass Spectrometric 8-Protein Signature Including Amyloid A Utilizing Serum Prognostic And Predictive Algorithm Reported As Good Versus Poor Overall Survival	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
81539	Oncology (High-Grade Prostate Cancer) Biochemical Assay Of Four Proteins (Total Psa Free Psa Intact Psa And Human Kallikrein-2 [Hk2]) Utilizing Plasma Or Serum Prognostic Algorithm Reported As A Probability Score	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
81599	Unlisted Multianalyte Assay With Algorithmic Analysis	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
82523	Collagen Cross Links Any Method	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
82777	Galectin-3	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
83006	Growth Stimulation Expressed Gene 2 (St2 Interleukin 1 Receptor Like-1)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
83695	Lipoprotein (A)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
83698	Lipoprotein-Associated Phospholipase A2 (Lp-Pla2)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_

83701	Lipoprotein Blood; High Resolution Fractionation And Quantitation Of Lipoproteins Including Lipoprotein Subclasses When Performed (Eg Electrophoresis Ultracentrifugation)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
83704	Lipoprotein Blood; Quantitation Of Lipoprotein Particle Number(S) (Eg By Nuclear Magnetic Resonance Spectroscopy) Includes Lipoprotein Particle Subclass(Es) When Performed	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
83722	Lipoprotein Direct Measurement; Small Dense Ldl Cholesterol	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
83937	Osteocalcin (Bone G1A 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).	_	_	_
83987	Ph; Exhaled Breath Condensate	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
84112	Evaluation Of Cervicovaginal Fluid For Specific Amniotic Fluid Protein(S) (Eg Placental Alpha Microglobulin-1 [Pamg-1] Placental Protein 12 [Pp12] Alpha-Fetoprotein) Qualitative Each Specimen	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
84431	Thromboxane Metabolite(S) Including Thromboxane If Performed Urine	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
84999	Unlisted Chemistry Procedure	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
85999	Unlisted Hematology And Coagulation 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 Quantitative Or Semiquantitative Each Allergen	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_

86328	Immunoassay For Infectious Agent Antibody(Ies) Qualitative Or Semiquantitative Single-Step Method (Eg Reagent Strip); Severe Acute Respiratory Syndrome Coronavirus 2 (Sars-Cov-2) (Coronavirus Disease [Covid-19])	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
86343	Leukocyte Histamine Release Test (Lhr)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
86352	Cellular Function Assay Involving Stimulation (Eg Mitogen Or Antigen) And Detection Of Biomarker (Eg Atp)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
86353	Lymphocyte Transformation Mitogen (Phytomitogen) Or Antigen Induced Blastogenesis	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
86408	Neutralizing Antibody Severe Acute Respiratory Syndrome Coronavirus 2 (Sars-Cov-2) (Coronavirus Disease [Covid-19]); Screen	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
86409	Neutralizing Antibody Severe Acute Respiratory Syndrome Coronavirus 2 (Sars-Cov-2) (Coronavirus Disease [Covid-19]); Titer	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
86413	Severe Acute Respiratory Syndrome Coronavirus 2 (Sars-Cov-2) (Coronavirus Disease [Covid-19]) Antibody Quantitative	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
86486	Skin Test; Unlisted Antigen Each	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
86769	Antibody; Severe Acute Respiratory Syndrome Coronavirus 2 (Sars-Cov-2) (Coronavirus Disease [Covid-19])	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
86849	Unlisted 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 For Paternity Testing Per Individual; Abo Rh And Mn	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_

86950	Leukocyte Transfusion	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
86999	Unlisted Transfusion Medicine Procedure	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
87505	Infectious Agent Detection By Nucleic Acid (Dna Or Rna); Gastrointestinal Pathogen (Eg Clostridium Difficile E. Coli Salmonella Shigella Norovirus Giardia) Includes Multiplex Reverse Transcription When Performed And Multiplex Amplified Probe Technique Multiple Types Or Subtypes 3-5 Targets	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
87506	Infectious Agent Detection By Nucleic Acid (Dna Or Rna); Gastrointestinal Pathogen (Eg Clostridium Difficile E. Coli Salmonella Shigella Norovirus Giardia) Includes Multiplex Reverse Transcription When Performed And Multiplex Amplified Probe Technique Multiple Types Or Subtypes 6-11 Targets	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
87507	Infectious Agent Detection By Nucleic Acid (Dna Or Rna); Gastrointestinal Pathogen (Eg Clostridium Difficile E. Coli Salmonella Shigella Norovirus Giardia) Includes Multiplex Reverse Transcription When Performed And Multiplex Amplified Probe Technique Multiple Types Or Subtypes 12-25 Targets	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
87797	Infectious Agent Detection By Nucleic Acid (Dna Or Rna) Not Otherwise Specified; Direct Probe Technique Each Organism	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
87798	Infectious Agent Detection By Nucleic Acid (Dna Or Rna) Not Otherwise Specified; Amplified Probe Technique Each Organism	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
87799	Infectious Agent Detection By Nucleic Acid (Dna Or Rna) Not Otherwise Specified; Quantification Each Organism	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
87899	Infectious Agent Antigen Detection By Immunoassay With Direct Optical (Ie Visual) Observation; Not Otherwise Specified	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
87999	Unlisted Microbiology Procedure	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
88099	Unlisted Necropsy (Autopsy) Procedure	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
88199	Unlisted Cytopathology Procedure	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_

88299	Unlisted Cytogenetic Study	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
88375	Optical Endomicroscopic Image(S) Interpretation And Report Real-Time Or Referred Each Endoscopic 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).	_	_	_
88399	Unlisted Surgical Pathology Procedure	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
88749	Unlisted In Vivo (Eg Transcutaneous) Laboratory Service	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
89240	Unlisted Miscellaneous Pathology Test	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
89250	Culture Of Oocyte(S)/Embryo(S) Less Than 4 Days;	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
89251	Culture Of Oocyte(S)/Embryo(S) Less Than 4 Days; With Co-Culture Of Oocyte(S)/Embryos	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
89253	Assisted Embryo Hatching Microtechniques (Any Method)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
89254	Oocyte Identification From Follicular Fluid	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89255	Preparation Of Embryo For Transfer (Any Method)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89257	Sperm Identification From Aspiration (Other Than Seminal Fluid)	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 Prep (Eg Sperm Wash And Swim-Up) For Insemination Or Diagnosis With Semen Analysis	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_

89261	Sperm Isolation; Complex Prep (Eg Percoll Gradient Albumin Gradient) For Insemination Or Diagnosis With Semen Analysis	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89264	Sperm Identification From Testis Tissue Fresh Or Cryopreserved	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 Oocyte(S)/Embryo(S) 4-7 Days	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89280	Assisted Oocyte Fertilization Microtechnique; Less Than Or Equal To 10 Oocytes	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89281	Assisted Oocyte Fertilization Microtechnique; Greater Than 10 Oocytes	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89290	Biopsy Oocyte Polar Body Or Embryo Blastomere Microtechnique (For Pre-Implantation Genetic Diagnosis); Less Than Or Equal To 5 Embryos	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
89291	Biopsy Oocyte Polar Body Or Embryo Blastomere Microtechnique (For Pre-Implantation Genetic Diagnosis); Greater Than 5 Embryos	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
89325	Sperm Antibodies	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89329	Sperm Evaluation; Hamster Penetration Test	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89330	Sperm Evaluation; Cervical Mucus Penetration Test With Or Without Spinnbarkeit Test	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89331	Sperm Evaluation For Retrograde Ejaculation Urine (Sperm Concentration Motility And Morphology As Indicated)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89335	Cryopreservation Reproductive Tissue Testicular	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89337	Cryopreservation Mature Oocyte(S)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89342	Storage (Per Year); Embryo(S)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89343	Storage (Per Year); Sperm/Semen	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89344	Storage (Per Year); Reproductive Tissue Testicular/Ovarian	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89346	Storage (Per Year); Oocyte(S)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_

89352	Thawing Of Cryopreserved; Embryo(S)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89353	Thawing Of Cryopreserved; Sperm/Semen Each Aliquot	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89354	Thawing Of Cryopreserved; Reproductive Tissue Testicular/Ovarian	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89356	Thawing Of Cryopreserved; Oocytes Each Aliquot	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
89398	Unlisted Reproductive Medicine Laboratory Procedure	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
90283	Immune Globulin (Igiv) Human For Intravenous Use	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
90284	Immune Globulin (Scig) Human For Use In Subcutaneous Infusions 100 Mg Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
90378	Respiratory Syncytial Virus Monoclonal Antibody Recombinant For Intramuscular Use 50 Mg Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
90399	Unlisted Immune Globulin	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
90584	Dengue Vaccine Quadrivalent Live 2 Dose Schedule For Subcutaneous Use	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
90626	Tick-Borne Encephalitis Virus Vaccine Inactivated; 0.25 Ml Dosage For Intramuscular Use	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
90627	Tick-Borne Encephalitis Virus Vaccine Inactivated; 0.5 Ml Dosage For Intramuscular Use	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
90664	Influenza Virus Vaccine Live (Laiv) Pandemic Formulation For Intranasal Use	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

90666	Influenza Virus Vaccine (Iiv) Pandemic Formulation Split Virus Preservative Free For Intramuscular Use	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
90667	Influenza Virus Vaccine (Iiv) Pandemic Formulation Split Virus Adjuvanted For Intramuscular Use	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
90683	Respiratory Syncytial Virus Vaccine Mrna Lipid Nanoparticles For Intramuscular Use	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
90749	Unlisted Vaccine/Toxoid	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
90759	Hepatitis B Vaccine (Hepb) 3-Antigen (S Pre-S1 Pre-S2) 10 Mcg Dosage 3 Dose Schedule For Intramuscular Use	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
90867	Therapeutic Repetitive Transcranial Magnetic Stimulation (Tms) Treatment; Initial Including Cortical Mapping Motor Threshold Determination Delivery And Management	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
90868	Therapeutic Repetitive Transcranial Magnetic Stimulation (Tms) Treatment; Subsequent Delivery And Management Per Session	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
90869	Therapeutic Repetitive Transcranial Magnetic Stimulation (Tms) Treatment; Subsequent Motor Threshold Re-Determination With Delivery And Management	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
90875	Individual Psychophysiological Therapy Incorporating Biofeedback Training By Any Modality (Face-To-Face With The Patient) With Psychotherapy (Eg Insight Oriented Behavior Modifying Or Supportive Psychotherapy); 30 Minutes	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
90876	Individual Psychophysiological Therapy Incorporating Biofeedback Training By Any Modality (Face-To-Face With The Patient) With Psychotherapy (Eg Insight Oriented Behavior Modifying Or Supportive Psychotherapy); 45 Minutes	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
90880x	Hypnotherapy	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	5/31/2024	Retire effective 5/31/2024

90885	Psychiatric Evaluation Of Hospital Records Other Psychiatric Reports Psychometric And/Or Projective Tests And Other Accumulated Data For Medical Diagnostic Purposes	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
90889	Preparation Of Report Of Patient'S Psychiatric Status History Treatment Or Progress (Other Than For Legal Or Consultative Purposes) For Other Individuals Agencies Or Insurance Carriers	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
90899	Unlisted Psychiatric Service Or Procedure	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
90901	Biofeedback Training By Any Modality	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
90912	Biofeedback Training Perineal Muscles Anorectal Or Urethral Sphincter Including Emg And/Or Manometry When Performed; Initial 15 Minutes Of One-On-One Physician Or Other Qualified Health Care Professional Contact With The Patient	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
90913	Biofeedback Training Perineal Muscles Anorectal Or Urethral Sphincter Including Emg And/Or Manometry When Performed; Each Additional 15 Minutes Of One-On-One Physician Or Other Qualified Health Care Professional Contact With The Patient (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
90999	Unlisted Dialysis Procedure Inpatient Or Outpatient	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
91034	Esophagus Gastroesophageal Reflux Test; With Nasal Catheter Ph Electrode(S) Placement Recording Analysis And Interpretation	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
91035	Esophagus Gastroesophageal Reflux Test; With Mucosal Attached Telemetry Ph Electrode Placement Recording Analysis And Interpretation	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
91037	Esophageal Function Test Gastroesophageal Reflux Test With Nasal Catheter Intraluminal Impedance Electrode(S) Placement Recording Analysis And Interpretation;	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

91038	Esophageal Function Test Gastroesophageal Reflux Test With Nasal Catheter Intraluminal Impedance Electrode(S) Placement Recording Analysis And Interpretation; Prolonged (Greater Than 1 Hour Up To 24 Hours)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
91065	Breath Hydrogen Or Methane Test (Eg For Detection Of Lactase Deficiency Fructose Intolerance Bacterial Overgrowth Or Oro-Cecal Gastrointestinal Transit)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
91110	Gastrointestinal Tract Imaging Intraluminal (Eg Capsule Endoscopy) Esophagus Through Ileum With Interpretation And Report	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
91111	Gastrointestinal Tract Imaging Intraluminal (Eg Capsule Endoscopy) Esophagus With Interpretation And Report	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
91112	Gastrointestinal Transit And Pressure Measurement Stomach Through Colon Wireless Capsule With Interpretation And Report	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
91113	Gastrointestinal Tract Imaging Intraluminal (Eg Capsule Endoscopy) Colon With Interpretation And Report	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
91117	Colon Motility (Manometric) Study Minimum 6 Hours Continuous Recording (Including Provocation Tests Eg Meal Intracolonic Balloon Distension Pharmacologic Agents If Performed) With Interpretation And Report	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
91132	Electrogastrography Diagnostic Transcutaneous;	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
91133	Electrogastrography Diagnostic Transcutaneous; With Provocative Testing	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
91299	Unlisted Diagnostic Gastroenterology Procedure	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
92065	Orthoptic Training; Performed By A Physician Or Other Qualified Health Care Professional	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

92066	Orthoptic Training; Under Supervision Of A Physician Or Other Qualified Health Care Professional	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
92132	Scanning Computerized Ophthalmic Diagnostic Imaging Anterior Segment With Interpretation And Report Unilateral Or 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).	_	_	_
92145	Corneal Hysteresis Determination By Air Impulse Stimulation Unilateral Or Bilateral With Interpretation And Report	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
92273	Electroretinography (Erg) With Interpretation And Report; Full Field (Ie Fferg Flash Erg Ganzfeld Erg)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
92274	Electroretinography (Erg) With Interpretation And Report; Multifocal (Mferg)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
92499	Unlisted Ophthalmological 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 (Eg Rhinomanometry)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
92517	Vestibular Evoked Myogenic Potential (Vemp) Testing With Interpretation And Report; Cervical (Cvemp)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
92518	Vestibular Evoked Myogenic Potential (Vemp) Testing With Interpretation And Report; Ocular (Ovemp)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
92519	Vestibular Evoked Myogenic Potential (Vemp) Testing With Interpretation And Report; Cervical (Cvemp) And Ocular (Ovemp)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
92520	Laryngeal Function Studies (Ie Aerodynamic Testing And Acoustic Testing)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

92548	Computerized Dynamic Posturography Sensory Organization Test (Cdp-Sot) 6 Conditions (Ie Eyes Open Eyes Closed Visual Sway Platform Sway Eyes Closed Platform Sway Platform And Visual Sway) Including Interpretation And Report;	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
92549	Computerized Dynamic Posturography Sensory Organization Test (Cdp-Sot) 6 Conditions (Ie Eyes Open Eyes Closed Visual Sway Platform Sway Eyes Closed Platform Sway Platform And Visual Sway) Including Interpretation And Report; With Motor Control Test (Mct) And Adaptation Test (Adt)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
92601	Diagnostic Analysis Of Cochlear Implant Patient Younger Than 7 Years Of Age; With Programming	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
92602	Diagnostic Analysis Of Cochlear Implant Patient Younger Than 7 Years Of Age; Subsequent Reprogramming	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
92603	Diagnostic Analysis Of Cochlear Implant Age 7 Years Or Older; With Programming	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
92622	Diagnostic Analysis Programming And Verification Of An Auditory Osseointegrated Sound Processor Any Type; First 60 Minutes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
92623	Diagnostic Analysis Programming And Verification Of An Auditory Osseointegrated Sound Processor Any Type; Each Additional 15 Minutes (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
92640	Diagnostic Analysis With Programming Of Auditory Brainstem Implant Per Hour	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
92700	Unlisted Otorhinolaryngological Service Or Procedure	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
92971	Cardioassist-Method Of Circulatory Assist; External	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

92972	Percutaneous Transluminal Coronary Lithotripsy (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
92974	Transcatheter Placement Of Radiation Delivery Device For Subsequent Coronary Intravascular Brachytherapy (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
92978	Endoluminal Imaging Of Coronary Vessel Or Graft Using Intravascular Ultrasound (Ivus) Or Optical Coherence Tomography (Oct) During Diagnostic Evaluation And/Or Therapeutic Intervention Including Imaging Supervision Interpretation And Report; Initial Vessel (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
92979	Endoluminal Imaging Of Coronary Vessel Or Graft Using Intravascular Ultrasound (Ivus) Or Optical Coherence Tomography (Oct) During Diagnostic Evaluation And/Or Therapeutic Intervention Including Imaging Supervision Interpretation And Report; Each Additional Vessel (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
93025	Microvolt T-Wave Alternans For Assessment Of Ventricular Arrhythmias	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
93050	Arterial Pressure Waveform Analysis For Assessment Of Central Arterial Pressures Includes Obtaining Waveform(S) Digitization And Application Of Nonlinear Mathematical Transformations To Determine Central Arterial Pressures And Augmentation Index With Interpretation And Report Upper Extremity Artery Non-Invasive	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
93150	Therapy Activation Of Implanted Phrenic Nerve Stimulator System Including All Interrogation And Programming	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	5/14/2024	Retire effective 05/14/2024
93150	Therapy Activation Of Implanted Phrenic Nerve Stimulator System Including All Interrogation And Programming	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024
93151	Interrogation And Programming (Minimum One Parameter) Of Implanted Phrenic Nerve Stimulator System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	5/14/2024	Retire effective 05/14/2024
93151	Interrogation And Programming (Minimum One Parameter) Of Implanted Phrenic Nerve Stimulator System	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024
93152	Interrogation And Programming Of Implanted Phrenic Nerve Stimulator System During Polysomnography	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	5/14/2024	Retire effective 05/14/2024

93152	Interrogation And Programming Of Implanted Phrenic Nerve Stimulator System During Polysomnography	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024
93153	Interrogation Without Programming Of Implanted Phrenic Nerve Stimulator System	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	5/14/2024	Retire effective 05/14/2024
93153	Interrogation Without Programming Of Implanted Phrenic Nerve Stimulator System	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024
93228	External Mobile Cardiovascular Telemetry With Electrocardiographic Recording Concurrent Computerized Real Time Data Analysis And Greater Than 24 Hours Of Accessible Ecg Data Storage (Retrievable With Query) With Ecg Triggered And Patient Selected Events Transmitted To A Remote Attended Surveillance Center For Up To 30 Days; Review And Interpretation With Report By A Physician Or Other Qualified Health Care Professional	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
93229	External Mobile Cardiovascular Telemetry With Electrocardiographic Recording Concurrent Computerized Real Time Data Analysis And Greater Than 24 Hours Of Accessible Ecg Data Storage (Retrievable With Query) With Ecg Triggered And Patient Selected Events Transmitted To A Remote Attended Surveillance Center For Up To 30 Days; Technical Support For Connection And Patient Instructions For Use Attended Surveillance Analysis And Transmission Of Daily And Emergent Data Reports As Prescribed By A Physician Or Other Qualified Health Care Professional	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
93260	Programming Device Evaluation (In Person) With Iterative Adjustment Of The Implantable Device To Test The Function Of The Device And Select Optimal Permanent Programmed Values With Analysis Review And Report By A Physician Or Other Qualified Health Care Professional; Implantable Subcutaneous Lead Defibrillator System	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
93261	Interrogation Device Evaluation (In Person) With Analysis Review And Report By A Physician Or Other Qualified Health Care Professional Includes Connection Recording And Disconnection Per Patient Encounter; Implantable Subcutaneous Lead Defibrillator System	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
93264	Remote Monitoring Of A Wireless Pulmonary Artery Pressure Sensor For Up To 30 Days Including At Least Weekly Downloads Of Pulmonary Artery Pressure Recordings Interpretation(S) Trend Analysis And Report(S) By A Physician Or Other Qualified Health Care Professional	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

93278	Signal-Averaged Electrocardiography (Saecg) With Or Without Ecg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
93356	Myocardial Strain Imaging Using Speckle Tracking-Derived Assessment Of Myocardial Mechanics (List Separately In Addition To Codes For Echocardiography Imaging)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
93580	Percutaneous Transcatheter Closure Of Congenital Interatrial Communication (Ie Fontan Fenestration Atrial Septal Defect) With Implant	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
93640	Electrophysiologic Evaluation Of Single Or Dual Chamber Pacing Cardioverter-Defibrillator Leads Including Defibrillation Threshold Evaluation (Induction Of Arrhythmia Evaluation Of Sensing And Pacing For Arrhythmia Termination) At Time Of Initial Implantation Or Replacement;	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
93641	Electrophysiologic Evaluation Of Single Or Dual Chamber Pacing Cardioverter-Defibrillator Leads Including Defibrillation Threshold Evaluation (Induction Of Arrhythmia Evaluation Of Sensing And Pacing For Arrhythmia Termination) At Time Of Initial Implantation Or Replacement; With Testing Of Single Or Dual Chamber Pacing Cardioverter-Defibrillator Pulse Generator	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
93642	Electrophysiologic Evaluation Of Single Or Dual Chamber Transvenous Pacing Cardioverter-Defibrillator (Includes Defibrillation Threshold Evaluation Induction Of Arrhythmia Evaluation Of Sensing And Pacing For Arrhythmia Termination And Programming Or Reprogramming Of Sensing Or Therapeutic Parameters)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
93644	Electrophysiologic Evaluation Of Subcutaneous Implantable Defibrillator (Includes Defibrillation Threshold Evaluation Induction Of Arrhythmia Evaluation Of Sensing For Arrhythmia Termination And Programming Or Reprogramming Of Sensing Or Therapeutic Parameters)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
93660	Evaluation Of Cardiovascular Function With Tilt Table Evaluation With Continuous Ecg Monitoring And Intermittent Blood Pressure Monitoring With Or Without Pharmacological Intervention	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

93701	Bioimpedance-Derived Physiologic Cardiovascular Analysis	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
93702	Bioimpedance Spectroscopy (Bis) Extracellular Fluid Analysis For Lymphedema Assessment(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).	_	_	_
93740	Temperature Gradient Studies	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
93797	Physician Or Other Qualified Health Care Professional Services For Outpatient Cardiac Rehabilitation; Without Continuous Ecg Monitoring (Per Session)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
93798	Physician Or Other Qualified Health Care Professional Services For Outpatient Cardiac Rehabilitation; With Continuous Ecg Monitoring (Per Session)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
93799	Unlisted Cardiovascular Service Or Procedure	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
93886	Transcranial Doppler Study Of The Intracranial Arteries; Complete Study	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
93888	Transcranial Doppler Study Of The Intracranial Arteries; Limited Study	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
93890	Transcranial Doppler Study Of The Intracranial Arteries; Vasoreactivity Study	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
93892	Transcranial Doppler Study Of The Intracranial Arteries; Emboli Detection Without Intravenous Microbubble Injection	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

93893	Transcranial Doppler Study Of The Intracranial Arteries; Emboli Detection With Intravenous Microbubble Injection	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
93998	Unlisted Noninvasive Vascular Diagnostic Study	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
94014	Patient-Initiated Spirometric Recording Per 30-Day Period Of Time; Includes Reinforced Education Transmission Of Spirometric Tracing Data Capture Analysis Of Transmitted Data Periodic Recalibration And Review And Interpretation By A Physician Or Other Qualified Health Care Professional	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
94015	Patient-Initiated Spirometric Recording Per 30-Day Period Of Time; Recording (Includes Hook-Up Reinforced Education Data Transmission Data Capture Trend Analysis And Periodic Recalibration)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
94016	Patient-Initiated Spirometric Recording Per 30-Day Period Of Time; Review And Interpretation Only By A Physician Or Other Qualified Health Care Professional	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
94669	Mechanical Chest Wall Oscillation To Facilitate Lung Function Per Session	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
94774	Pediatric Home Apnea Monitoring Event Recording Including Respiratory Rate Pattern And Heart Rate Per 30-Day Period Of Time; Includes Monitor Attachment Download Of Data Review Interpretation And Preparation Of A Report By A Physician Or Other Qualified Health Care Professional	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
94775	Pediatric Home Apnea Monitoring Event Recording Including Respiratory Rate Pattern And Heart Rate Per 30-Day Period Of Time; Monitor Attachment Only (Includes Hook-Up Initiation Of Recording And Disconnection)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
94776	Pediatric Home Apnea Monitoring Event Recording Including Respiratory Rate Pattern And Heart Rate Per 30-Day Period Of Time; Monitoring Download Of Information Receipt Of Transmission(S) And Analyses By Computer Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

94777	Pediatric Home Apnea Monitoring Event Recording Including Respiratory Rate Pattern And Heart Rate Per 30-Day Period Of Time; Review Interpretation And Preparation Of Report Only By A Physician Or Other Qualified Health Care Professional	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
94799	Unlisted Pulmonary Service Or Procedure	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
95060	Ophthalmic Mucous Membrane Tests	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
95065	Direct Nasal Mucous Membrane Test	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
95199	Unlisted Allergy/Clinical Immunologic Service Or Procedure	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
95700	Electroencephalogram (Eeg) Continuous Recording With Video When Performed Setup Patient Education And Takedown When Performed Administered In Person By Eeg Technologist Minimum Of 8 Channels	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
95705	Electroencephalogram (Eeg) Without Video Review Of Data Technical Description By Eeg Technologist 2-12 Hours; Unmonitored	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
95706	Electroencephalogram (Eeg) Without Video Review Of Data Technical Description By Eeg Technologist 2-12 Hours; With Intermittent Monitoring And Maintenance	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
95707	Electroencephalogram (Eeg) Without Video Review Of Data Technical Description By Eeg Technologist 2-12 Hours; With Continuous Real-Time Monitoring And Maintenance	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
95708	Electroencephalogram (Eeg) Without Video Review Of Data Technical Description By Eeg Technologist Each Increment Of 12-26 Hours; Unmonitored	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

95709	Electroencephalogram (Eeg) Without Video Review Of Data Technical Description By Eeg Technologist Each Increment Of 12-26 Hours; With Intermittent Monitoring And Maintenance	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
95710	Electroencephalogram (Eeg) Without Video Review Of Data Technical Description By Eeg Technologist Each Increment Of 12-26 Hours; With Continuous Real-Time Monitoring And Maintenance	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
95711	Electroencephalogram With Video (Veeg) Review Of Data Technical Description By Eeg Technologist 2-12 Hours; Unmonitored	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
95712	Electroencephalogram With Video (Veeg) Review Of Data Technical Description By Eeg Technologist 2-12 Hours; With Intermittent Monitoring And Maintenance	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
95713	Electroencephalogram With Video (Veeg) Review Of Data Technical Description By Eeg Technologist 2-12 Hours; With Continuous Real-Time Monitoring And Maintenance	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
95714	Electroencephalogram With Video (Veeg) Review Of Data Technical Description By Eeg Technologist Each Increment Of 12-26 Hours; Unmonitored	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
95715	Electroencephalogram With Video (Veeg) Review Of Data Technical Description By Eeg Technologist Each Increment Of 12-26 Hours; With Intermittent Monitoring And Maintenance	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
95716	Electroencephalogram With Video (Veeg) Review Of Data Technical Description By Eeg Technologist Each Increment Of 12-26 Hours; With Continuous Real-Time Monitoring And Maintenance	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
95717	Electroencephalogram (Eeg) Continuous Recording Physician Or Other Qualified Health Care Professional Review Of Recorded Events Analysis Of Spike And Seizure Detection Interpretation And Report 2-12 Hours Of Eeg Recording; Without Video	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

95718	Electroencephalogram (Eeg) Continuous Recording Physician Or Other Qualified Health Care Professional Review Of Recorded Events Analysis Of Spike And Seizure Detection Interpretation And Report 2-12 Hours Of Eeg Recording; With Video (Veeg)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
95719	Electroencephalogram (Eeg) Continuous Recording Physician Or Other Qualified Health Care Professional Review Of Recorded Events Analysis Of Spike And Seizure Detection Each Increment Of Greater Than 12 Hours Up To 26 Hours Of Eeg Recording Interpretation And Report After Each 24-Hour Period; Without Video	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
95720	Electroencephalogram (Eeg) Continuous Recording Physician Or Other Qualified Health Care Professional Review Of Recorded Events Analysis Of Spike And Seizure Detection Each Increment Of Greater Than 12 Hours Up To 26 Hours Of Eeg Recording Interpretation And Report After Each 24-Hour Period; With Video (Veeg)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
95721	Electroencephalogram (Eeg) Continuous Recording Physician Or Other Qualified Health Care Professional Review Of Recorded Events Analysis Of Spike And Seizure Detection Interpretation And Summary Report Complete Study; Greater Than 36 Hours Up To 60 Hours Of Eeg Recording Without Video	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
95722	Electroencephalogram (Eeg) Continuous Recording Physician Or Other Qualified Health Care Professional Review Of Recorded Events Analysis Of Spike And Seizure Detection Interpretation And Summary Report Complete Study; Greater Than 36 Hours Up To 60 Hours Of Eeg Recording With Video (Veeg)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
95723	Electroencephalogram (Eeg) Continuous Recording Physician Or Other Qualified Health Care Professional Review Of Recorded Events Analysis Of Spike And Seizure Detection Interpretation And Summary Report Complete Study; Greater Than 60 Hours Up To 84 Hours Of Eeg Recording Without Video	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
95724	Electroencephalogram (Eeg) Continuous Recording Physician Or Other Qualified Health Care Professional Review Of Recorded Events Analysis Of Spike And Seizure Detection Interpretation And Summary Report Complete Study; Greater Than 60 Hours Up To 84 Hours Of Eeg Recording With Video (Veeg)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
95725	Electroencephalogram (Eeg) Continuous Recording Physician Or Other Qualified Health Care Professional Review Of Recorded Events Analysis Of Spike And Seizure Detection Interpretation And Summary Report Complete Study; Greater Than 84 Hours Of Eeg Recording Without Video	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

95726	Electroencephalogram (Eeg) Continuous Recording Physician Or Other Qualified Health Care Professional Review Of Recorded Events Analysis Of Spike And Seizure Detection Interpretation And Summary Report Complete Study; Greater Than 84 Hours Of Eeg Recording With Video (Veeg)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
95782	Polysomnography; Younger Than 6 Years Sleep Staging With 4 Or More Additional Parameters Of Sleep Attended By A Technologist	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
95783	Polysomnography; Younger Than 6 Years Sleep Staging With 4 Or More Additional Parameters Of Sleep With Initiation Of Continuous Positive Airway Pressure Therapy Or Bi-Level Ventilation Attended By A Technologist	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
95803	Actigraphy Testing Recording Analysis Interpretation And Report (Minimum Of 72 Hours To 14 Consecutive Days Of Recording)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
95805	Multiple Sleep Latency Or Maintenance Of Wakefulness Testing Recording Analysis And Interpretation Of Physiological Measurements Of Sleep During Multiple Trials To Assess Sleepiness	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
95807	Sleep Study Simultaneous Recording Of Ventilation Respiratory Effort Ecg Or Heart Rate And Oxygen Saturation Attended By A Technologist	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
95808	Polysomnography; Any Age Sleep Staging With 1-3 Additional Parameters Of Sleep Attended By A Technologist	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
95810	Polysomnography; Age 6 Years Or Older Sleep Staging With 4 Or More Additional Parameters Of Sleep Attended By A Technologist	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
95811	Polysomnography; Age 6 Years Or Older Sleep Staging With 4 Or More Additional Parameters Of Sleep With Initiation Of Continuous Positive Airway Pressure Therapy Or Bilevel Ventilation Attended By A Technologist	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

95905	Motor And/Or Sensory Nerve Conduction Using Preconfigured Electrode Array(S) Amplitude And Latency/Velocity Study Each Limb Includes F-Wave Study When Performed With Interpretation And Report	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
95919	Quantitative Pupillometry With Physician Or Other Qualified Health Care Professional Interpretation And Report Unilateral Or 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).	_	_	_
95954	Pharmacological Or Physical Activation Requiring Physician Or Other Qualified Health Care Professional Attendance During Eeg Recording Of Activation Phase (Eg Thiopental Activation Test)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
95957	Digital Analysis Of Electroencephalogram (Eeg) (Eg For Epileptic Spike Analysis)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
95961	Functional Cortical And Subcortical Mapping By Stimulation And/Or Recording Of Electrodes On Brain Surface Or Of Depth Electrodes To Provoke Seizures Or Identify Vital Brain Structures; Initial Hour Of Attendance By A Physician Or Other Qualified Health Care Professional	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
95962	Functional Cortical And Subcortical Mapping By Stimulation And/Or Recording Of Electrodes On Brain Surface Or Of Depth Electrodes To Provoke Seizures Or Identify Vital Brain Structures; Each Additional Hour Of Attendance By A Physician Or Other Qualified Health Care Professional (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
95965	Magnetoencephalography (Meg) Recording And Analysis; For Spontaneous Brain Magnetic Activity (Eg Epileptic Cerebral Cortex Localization)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
95966	Magnetoencephalography (Meg) Recording And Analysis; For Evoked Magnetic Fields Single Modality (Eg Sensory Motor Language Or Visual Cortex Localization)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
95967	Magnetoencephalography (Meg) Recording And Analysis; For Evoked Magnetic Fields Each Additional Modality (Eg Sensory Motor Language Or Visual Cortex Localization) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

95970	Electronic Analysis Of Implanted Neurostimulator Pulse Generator/Transmitter (Eg Contact Group[S] Interleaving Amplitude Pulse Width Frequency [Hz] On/Off Cycling Burst Magnet Mode Dose Lockout Patient Selectable Parameters Responsive Neurostimulation Detection Algorithms Closed Loop Parameters And Passive Parameters) By Physician Or Other Qualified Health Care Professional; With Brain Cranial Nerve Spinal Cord Peripheral Nerve Or Sacral Nerve Neurostimulator Pulse Generator/Transmitter Without Programming	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
95971	Electronic Analysis Of Implanted Neurostimulator Pulse Generator/Transmitter (Eg Contact Group[S] Interleaving Amplitude Pulse Width Frequency [Hz] On/Off Cycling Burst Magnet Mode Dose Lockout Patient Selectable Parameters Responsive Neurostimulation Detection Algorithms Closed Loop Parameters And Passive Parameters) By Physician Or Other Qualified Health Care Professional; With Simple Spinal Cord Or Peripheral Nerve (Eg Sacral Nerve) Neurostimulator Pulse Generator/Transmitter Programming By Physician Or Other Qualified Health Care Professional	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
95972	Electronic Analysis Of Implanted Neurostimulator Pulse Generator/Transmitter (Eg Contact Group[S] Interleaving Amplitude Pulse Width Frequency [Hz] On/Off Cycling Burst Magnet Mode Dose Lockout Patient Selectable Parameters Responsive Neurostimulation Detection Algorithms Closed Loop Parameters And Passive Parameters) By Physician Or Other Qualified Health Care Professional; With Complex Spinal Cord Or Peripheral Nerve (Eg Sacral Nerve) Neurostimulator Pulse Generator/Transmitter Programming By Physician Or Other Qualified Health Care Professional	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
95976	Electronic Analysis Of Implanted Neurostimulator Pulse Generator/Transmitter (Eg Contact Group[S] Interleaving Amplitude Pulse Width Frequency [Hz] On/Off Cycling Burst Magnet Mode Dose Lockout Patient Selectable Parameters Responsive Neurostimulation Detection Algorithms Closed Loop Parameters And Passive Parameters) By Physician Or Other Qualified Health Care Professional; With Simple Cranial Nerve Neurostimulator Pulse Generator/Transmitter Programming By Physician Or Other Qualified Health Care Professional	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

95977	Electronic Analysis Of Implanted Neurostimulator Pulse Generator/Transmitter (Eg Contact Group[S] Interleaving Amplitude Pulse Width Frequency [Hz] On/Off Cycling Burst Magnet Mode Dose Lockout Patient Selectable Parameters Responsive Neurostimulation Detection Algorithms Closed Loop Parameters And Passive Parameters) By Physician Or Other Qualified Health Care Professional; With Complex Cranial Nerve Neurostimulator Pulse Generator/Transmitter Programming By Physician Or Other Qualified Health Care Professional	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
95981	Electronic Analysis Of Implanted Neurostimulator Pulse Generator System (Eg Rate Pulse Amplitude And Duration Configuration Of Wave Form Battery Status Electrode Selectability Output Modulation Cycling Impedance And Patient Measurements) Gastric Neurostimulator Pulse Generator/Transmitter; Subsequent Without Reprogramming	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
95982	Electronic Analysis Of Implanted Neurostimulator Pulse Generator System (Eg Rate Pulse Amplitude And Duration Configuration Of Wave Form Battery Status Electrode Selectability Output Modulation Cycling Impedance And Patient Measurements) Gastric Neurostimulator Pulse Generator/Transmitter; Subsequent With Reprogramming	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
95983	Electronic Analysis Of Implanted Neurostimulator Pulse Generator/Transmitter (Eg Contact Group[S] Interleaving Amplitude Pulse Width Frequency [Hz] On/Off Cycling Burst Magnet Mode Dose Lockout Patient Selectable Parameters Responsive Neurostimulation Detection Algorithms Closed Loop Parameters And Passive Parameters) By Physician Or Other Qualified Health Care Professional; With Brain Neurostimulator Pulse Generator/Transmitter Programming First 15 Minutes Face-To-Face Time With Physician Or Other Qualified Health Care Professional	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

95984	Electronic Analysis Of Implanted Neurostimulator Pulse Generator/Transmitter (Eg Contact Group[S] Interleaving Amplitude Pulse Width Frequency [Hz] On/Off Cycling Burst Magnet Mode Dose Lockout Patient Selectable Parameters Responsive Neurostimulation Detection Algorithms Closed Loop Parameters And Passive Parameters) By Physician Or Other Qualified Health Care Professional; With Brain Neurostimulator Pulse Generator/Transmitter Programming Each Additional 15 Minutes Face-To-Face Time With Physician Or Other Qualified Health Care Professional (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
95999	Unlisted Neurological Or Neuromuscular Diagnostic Procedure	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
96000	Comprehensive Computer-Based Motion Analysis By Video-Taping And 3D Kinematics;	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
96001	Comprehensive Computer-Based Motion Analysis By Video-Taping And 3D Kinematics; With Dynamic Plantar Pressure Measurements During Walking	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
96002	Dynamic Surface Electromyography During Walking Or Other Functional Activities 1-12 Muscles	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
96003	Dynamic Fine Wire Electromyography During Walking Or Other Functional Activities 1 Muscle	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
96004	Review And Interpretation By Physician Or Other Qualified Health Care Professional Of Comprehensive Computer-Based Motion Analysis Dynamic Plantar Pressure Measurements Dynamic Surface Electromyography During Walking Or Other Functional Activities And Dynamic Fine Wire Electromyography With Written Report	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
96379	Unlisted Therapeutic Prophylactic Or Diagnostic Intravenous Or Intra-Arterial Injection Or Infusion	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_

96547	Intraoperative Hyperthermic Intraperitoneal Chemotherapy (Hipec) Procedure Including Separate Incision(S) And Closure When Performed; First 60 Minutes (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
96548	Intraoperative Hyperthermic Intraperitoneal Chemotherapy (Hipec) Procedure Including Separate Incision(S) And Closure When Performed; Each Additional 30 Minutes (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
96549	Unlisted Chemotherapy Procedure	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
96567	Photodynamic Therapy By External Application Of Light To Destroy Premalignant Lesions Of The Skin And Adjacent Mucosa With Application And Illumination/Activation Of Photosensitive Drug(S) Per Day	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
96570	Photodynamic Therapy By Endoscopic Application Of Light To Ablate Abnormal Tissue Via Activation Of Photosensitive Drug(S); First 30 Minutes (List Separately In Addition To Code For Endoscopy Or Bronchoscopy Procedures Of Lung And Gastrointestinal Tract)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
96571	Photodynamic Therapy By Endoscopic Application Of Light To Ablate Abnormal Tissue Via Activation Of Photosensitive Drug(S); Each Additional 15 Minutes (List Separately In Addition To Code For Endoscopy Or Bronchoscopy Procedures Of Lung And Gastrointestinal Tract)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
96573	Photodynamic Therapy By External Application Of Light To Destroy Premalignant Lesions Of The Skin And Adjacent Mucosa With Application And Illumination/Activation Of Photosensitizing Drug(S) Provided By A Physician Or Other Qualified Health Care Professional Per Day	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
96574	Debridement Of Premalignant Hyperkeratotic Lesion(S) (Ie Targeted Curettage Abrasion) Followed With Photodynamic Therapy By External Application Of Light To Destroy Premalignant Lesions Of The Skin And Adjacent Mucosa With Application And Illumination/Activation Of Photosensitizing Drug(S) Provided By A Physician Or Other Qualified Health Care Professional Per Day	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
96912	Photochemotherapy; Psoralens And Ultraviolet A (Puva)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

96913	Photochemotherapy (Goeckerman And/Or Puva) For Severe Photoresponsive Dermatoses Requiring At Least 4-8 Hours Of Care Under Direct Supervision Of The Physician (Includes Application Of Medication And Dressings)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
96922	Excimer Laser Treatment For Psoriasis; Over 500 Sq Cm	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
96931	Reflectance Confocal Microscopy (Rcm) For Cellular And Sub-Cellular Imaging Of Skin; Image Acquisition And Interpretation And Report First Lesion	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
96932	Reflectance Confocal Microscopy (Rcm) For Cellular And Sub-Cellular Imaging Of Skin; Image Acquisition Only First Lesion	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
96933	Reflectance Confocal Microscopy (Rcm) For Cellular And Sub-Cellular Imaging Of Skin; Interpretation And Report Only First Lesion	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
96934	Reflectance Confocal Microscopy (Rcm) For Cellular And Sub-Cellular Imaging Of Skin; Image Acquisition And Interpretation And Report Each Additional Lesion (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
96935	Reflectance Confocal Microscopy (Rcm) For Cellular And Sub-Cellular Imaging Of Skin; Image Acquisition Only Each Additional Lesion (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
96936	Reflectance Confocal Microscopy (Rcm) For Cellular And Sub-Cellular Imaging Of Skin; Interpretation And Report Only Each Additional Lesion (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
96999	Unlisted Special Dermatological Service Or Procedure	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
97012	Application Of A Modality To 1 Or More Areas; Traction Mechanical	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_

97014	Application Of A Modality To 1 Or More Areas; Electrical Stimulation (Unattended)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
97024	Application Of A Modality To 1 Or More Areas; Diathermy (Eg Microwave)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
97032	Application Of A Modality To 1 Or More Areas; Electrical Stimulation (Manual) Each 15 Minutes	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
97037	Application Of A Modality To 1 Or More Areas; Low-Level Laser Therapy (Ie Nonthermal And Non-Ablative) For Post-Operative Pain Reduction	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
97039	Unlisted Modality (Specify Type And Time If Constant Attendance)	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
97124	Therapeutic Procedure 1 Or More Areas Each 15 Minutes; Massage Including Effleurage Petrissage And/Or Tapotement (Stroking Compression Percussion)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
97139	Unlisted Therapeutic Procedure (Specify)	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
97169	Athletic Training Evaluation Low Complexity Requiring These Components: A History And Physical Activity Profile With No Comorbidities That Affect Physical Activity; An Examination Of Affected Body Area And Other Symptomatic Or Related Systems Addressing 1-2 Elements From Any Of The Following: Body Structures Physical Activity And/Or Participation Deficiencies; And Clinical Decision Making Of Low Complexity Using Standardized Patient Assessment Instrument And/Or Measurable Assessment Of Functional Outcome. Typically 15 Minutes Are Spent Face-To-Face With The Patient And/Or Family.	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
97170	Athletic Training Evaluation Moderate Complexity Requiring These Components: A Medical History And Physical Activity Profile With 1-2 Comorbidities That Affect Physical Activity; An Examination Of Affected Body Area And Other Symptomatic Or Related Systems Addressing A Total Of 3 Or More Elements From Any Of The Following: Body Structures Physical Activity And/Or Participation Deficiencies; And Clinical Decision Making Of Moderate Complexity Using Standardized Patient Assessment Instrument And/Or Measurable Assessment Of Functional Outcome. Typically 30 Minutes Are Spent Face-To-Face With The Patient And/Or Family.	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_

97171	Athletic Training Evaluation High Complexity Requiring These Components: A Medical History And Physical Activity Profile With 3 Or More Comorbidities That Affect Physical Activity; A Comprehensive Examination Of Body Systems Using Standardized Tests And Measures Addressing A Total Of 4 Or More Elements From Any Of The Following: Body Structures Physical Activity And/Or Participation Deficiencies; Clinical Presentation With Unstable And Unpredictable Characteristics; And Clinical Decision Making Of High Complexity Using Standardized Patient Assessment Instrument And/Or Measurable Assessment Of Functional Outcome. Typically 45 Minutes Are Spent Face-To-Face With The Patient And/Or Family.	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
97172	Re-Evaluation Of Athletic Training Established Plan Of Care Requiring These Components: An Assessment Of Patient'S Current Functional Status When There Is A Documented Change; And A Revised Plan Of Care Using A Standardized Patient Assessment Instrument And/Or Measurable Assessment Of Functional Outcome With An Update In Management Options Goals And Interventions. Typically 20 Minutes Are Spent Face-To-Face With The Patient And/Or Family.	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
97533	Sensory Integrative Techniques To Enhance Sensory Processing And Promote Adaptive Responses To Environmental Demands Direct (One-On-One) Patient Contact Each 15 Minutes	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
97537	Community/Work Reintegration Training (Eg Shopping Transportation Money Management Avocational Activities And/Or Work Environment/Modification Analysis Work Task Analysis Use Of Assistive Technology Device/Adaptive Equipment) Direct One-On-One Contact Each 15 Minutes	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
97545	Work Hardening/Conditioning; Initial 2 Hours	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
97546	Work Hardening/Conditioning; Each Additional Hour (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

97605	Negative Pressure Wound Therapy (Eg Vacuum Assisted Drainage Collection) Utilizing Durable Medical Equipment (Dme) Including Topical Application(S) Wound Assessment And Instruction(S) For Ongoing Care Per Session; Total Wound(S) Surface Area Less Than Or Equal To 50 Square Centimeters	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
97606	Negative Pressure Wound Therapy (Eg Vacuum Assisted Drainage Collection) Utilizing Durable Medical Equipment (Dme) Including Topical Application(S) Wound Assessment And Instruction(S) For Ongoing Care Per Session; Total Wound(S) Surface Area Greater Than 50 Square Centimeters	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
97607	Negative Pressure Wound Therapy (Eg Vacuum Assisted Drainage Collection) Utilizing Disposable Non-Durable Medical Equipment Including Provision Of Exudate Management Collection System Topical Application(S) Wound Assessment And Instructions For Ongoing Care Per Session; Total Wound(S) Surface Area Less Than Or Equal To 50 Square Centimeters	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
97608	Negative Pressure Wound Therapy (Eg Vacuum Assisted Drainage Collection) Utilizing Disposable Non-Durable Medical Equipment Including Provision Of Exudate Management Collection System Topical Application(S) Wound Assessment And Instructions For Ongoing Care Per Session; Total Wound(S) Surface Area Greater Than 50 Square Centimeters	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
97610	Low Frequency Non-Contact Non-Thermal Ultrasound Including Topical Application(S) When Performed Wound Assessment And Instruction(S) For Ongoing Care Per 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).	_	_	_
97799	Unlisted Physical Medicine/Rehabilitation Service Or Procedure	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
97810	Acupuncture 1 Or More Needles; Without Electrical Stimulation Initial 15 Minutes Of Personal One-On-One Contact With The Patient	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
97811	Acupuncture 1 Or More Needles; Without Electrical Stimulation Each Additional 15 Minutes Of Personal One-On-One Contact With The Patient With Re-Insertion Of Needle(S) (List Separately In Addition To Code For Primary Procedure)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
97813	Acupuncture 1 Or More Needles; With Electrical Stimulation Initial 15 Minutes Of Personal One-On-One Contact With The Patient	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_

97814	Acupuncture 1 Or More Needles; With Electrical Stimulation Each Additional 15 Minutes Of Personal One-On-One Contact With The Patient With Re-Insertion Of Needle(S) (List Separately In Addition To Code For Primary Procedure)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
98962	Education And Training For Patient Self-Management By A Qualified Nonphysician Health Care Professional Using A Standardized Curriculum Face-To-Face With The Patient (Could Include Caregiver/Family) Each 30 Minutes; 5-8 Patients	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
98978	Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor cognitive behavioral therapy, each 30 days	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	2/29/2024	Retire effective 02/29/2024
99026	Hospital Mandated On Call Service; In-Hospital Each Hour	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
99027	Hospital Mandated On Call Service; Out-Of-Hospital Each Hour	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
99050	Services Provided In The Office At Times Other Than Regularly Scheduled Office Hours Or Days When The Office Is Normally Closed (Eg Holidays Saturday Or Sunday) In Addition To Basic Service	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
99056	Service(S) Typically Provided In The Office Provided Out Of The Office At Request Of Patient In Addition To Basic Service	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
99058	Service(S) Provided On An Emergency Basis In The Office Which Disrupts Other Scheduled Office Services In Addition To Basic Service	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
99070	Supplies And Materials (Except Spectacles) Provided By The Physician Or Other Qualified Health Care Professional Over And Above Those Usually Included With The Office Visit Or Other Services Rendered (List Drugs Trays Supplies Or Materials Provided)	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
99071	Educational Supplies Such As Books Tapes And Pamphlets For The Patient'S Education At Cost To Physician Or Other Qualified Health Care Professional	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
99075	Medical Testimony	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review. Unlisted or Undefined	_	_	_
99078	Physician Or Other Qualified Health Care Professional Qualified By Education Training Licensure/Regulation (When Applicable) Educational Services Rendered To Patients In A Group Setting (Eg Prenatal Obesity Or Diabetic Instructions)	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_

99080	Special Reports Such As Insurance Forms More Than The Information Conveyed In The Usual Medical Communications Or Standard Reporting Form	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review. Unlisted or Undefined	_	_	_
99082	Unusual Travel (Eg Transportation And Escort Of Patient)	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review. Unlisted or Undefined	_	_	_
99199	Unlisted Special Service Procedure Or Report	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
99360	Standby Service Requiring Prolonged Attendance Each 30 Minutes (Eg Operative Standby Standby For Frozen Section For Cesarean/High Risk Delivery For Monitoring Eeg)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
99424	Principal Care Management Services For A Single High-Risk Disease With The Following Required Elements: One Complex Chronic Condition Expected To Last At Least 3 Months And That Places The Patient At Significant Risk Of Hospitalization Acute Exacerbation/Decompensation Functional Decline Or Death The Condition Requires Development Monitoring Or Revision Of Disease-Specific Care Plan The Condition Requires Frequent Adjustments In The Medication Regimen And/Or The Management Of The Condition Is Unusually Complex Due To Comorbidities Ongoing Communication And Care Coordination Between Relevant Practitioners Furnishing Care; First 30 Minutes Provided Personally By A Physician Or Other Qualified Health Care Professional Per Calendar Month.	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	1/1/2024	Retire effective 01/01/2024
99425	Principal Care Management Services For A Single High-Risk Disease With The Following Required Elements: One Complex Chronic Condition Expected To Last At Least 3 Months And That Places The Patient At Significant Risk Of Hospitalization Acute Exacerbation/Decompensation Functional Decline Or Death The Condition Requires Development Monitoring Or Revision Of Disease-Specific Care Plan The Condition Requires Frequent Adjustments In The Medication Regimen And/Or The Management Of The Condition Is Unusually Complex Due To Comorbidities Ongoing Communication And Care Coordination Between Relevant Practitioners Furnishing Care; Each Additional 30 Minutes Provided Personally By A Physician Or Other Qualified Health Care Professional Per Calendar Month (List Separately In Addition To Code For Primary Procedure)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	1/1/2024	Retire effective 01/01/2024

99426	Principal Care Management Services For A Single High-Risk Disease With The Following Required Elements: One Complex Chronic Condition Expected To Last At Least 3 Months And That Places The Patient At Significant Risk Of Hospitalization Acute Exacerbation/Decompensation Functional Decline Or Death The Condition Requires Development Monitoring Or Revision Of Disease-Specific Care Plan The Condition Requires Frequent Adjustments In The Medication Regimen And/Or The Management Of The Condition Is Unusually Complex Due To Comorbidities Ongoing Communication And Care Coordination Between Relevant Practitioners Furnishing Care; First 30 Minutes Of Clinical Staff Time Directed By Physician Or Other Qualified Health Care Professional Per Calendar Month.	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	1/1/2024	Retire effective 01/01/2024
99427	Principal Care Management Services For A Single High-Risk Disease With The Following Required Elements: One Complex Chronic Condition Expected To Last At Least 3 Months And That Places The Patient At Significant Risk Of Hospitalization Acute Exacerbation/Decompensation Functional Decline Or Death The Condition Requires Development Monitoring Or Revision Of Disease-Specific Care Plan The Condition Requires Frequent Adjustments In The Medication Regimen And/Or The Management Of The Condition Is Unusually Complex Due To Comorbidities Ongoing Communication And Care Coordination Between Relevant Practitioners Furnishing Care; Each Additional 30 Minutes Of Clinical Staff Time Directed By A Physician Or Other Qualified Health Care Professional Per Calendar Month (List Separately In Addition To Code For Primary Procedure)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	1/1/2024	Retire effective 01/01/2024
99429	Unlisted Preventive Medicine Service	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
99450	Basic Life And/Or Disability Examination That Includes: Measurement Of Height Weight And Blood Pressure; Completion Of A Medical History Following A Life Insurance Pro Forma; Collection Of Blood Sample And/Or Urinalysis Complying With Chain Of Custody Protocols; And Completion Of Necessary Documentation/Certificates.	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_

99455	Work Related Or Medical Disability Examination By The Treating Physician That Includes: Completion Of A Medical History Commensurate With The Patient'S Condition; Performance Of An Examination Commensurate With The Patient'S Condition; Formulation Of A Diagnosis Assessment Of Capabilities And Stability And Calculation Of Impairment; Development Of Future Medical Treatment Plan; And Completion Of Necessary Documentation/Certificates And Report.	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
99456	Work Related Or Medical Disability Examination By Other Than The Treating Physician That Includes: Completion Of A Medical History Commensurate With The Patient'S Condition; Performance Of An Examination Commensurate With The Patient'S Condition; Formulation Of A Diagnosis Assessment Of Capabilities And Stability And Calculation Of Impairment; Development Of Future Medical Treatment Plan; And Completion Of Necessary Documentation/Certificates And Report.	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
99499	Unlisted Evaluation And Management Service	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
99509	Home Visit For Assistance With Activities Of Daily Living And Personal Care	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
99512	Home Visit For Hemodialysis	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
99600	Unlisted Home Visit Service Or Procedure	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
0052U	Lipoprotein Blood High Resolution Fractionation And Quantitation Of Lipoproteins Including All Five Major Lipoprotein Classes And Subclasses Of Hdl Ldl And Vldl By Vertical Auto Profile Ultracentrifugation	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0054T	Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedure With Image-Guidance Based On Fluoroscopic Images (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0055T	Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedure With Image-Guidance Based On Ct/Mri Images (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_

0062U	Autoimmune (Systemic Lupus Erythematosus) Igg And Igm Analysis Of 80 Biomarkers Utilizing Serum Algorithm Reported With A Risk Score	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0063U	Neurology (Autism) 32 Amines By Lc-Ms/Ms Using Plasma Algorithm Reported As Metabolic Signature Associated With Autism Spectrum Disorder	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0071T	Focused Ultrasound Ablation Of Uterine Leiomyomata Including Mr Guidance; Total Leiomyomata Volume Less Than 200 Cc Of Tissue	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0072T	Focused Ultrasound Ablation Of Uterine Leiomyomata Including Mr Guidance; Total Leiomyomata Volume Greater Or Equal To 200 Cc Of Tissue	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0075T	Transcatheter Placement Of Extracranial Vertebral Artery Stent(S) Including Radiologic Supervision And Interpretation Open Or Percutaneous; Initial Vessel	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0076T	Transcatheter Placement Of Extracranial Vertebral Artery Stent(S) Including Radiologic Supervision And Interpretation Open Or Percutaneous; Each Additional Vessel (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0100T	Placement Of A Subconjunctival Retinal Prosthesis Receiver And Pulse Generator And Implantation Of Intraocular Retinal Electrode Array With Vitrectomy	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0101T	Extracorporeal Shock Wave Involving Musculoskeletal System Not Otherwise Specified	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0102T	Extracorporeal Shock Wave Performed By A Physician Requiring Anesthesia Other Than Local And Involving The Lateral Humeral Epicondyle	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0106T	Quantitative Sensory Testing (Qst) Testing And Interpretation Per Extremity; Using Touch Pressure Stimuli To Assess Large Diameter Sensation	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_

0106U	Gastric Emptying Serial Collection Of 7 Timed Breath Specimens Non-Radioisotope Carbon-13 (13C) Spirulina Substrate Analysis Of Each Specimen By Gas Isotope Ratio Mass Spectrometry Reported As Rate Of 13Co2 Excretion	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0107T	Quantitative Sensory Testing (Qst) Testing And Interpretation Per Extremity; Using Vibration Stimuli To Assess Large Diameter Fiber Sensation	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0108T	Quantitative Sensory Testing (Qst) Testing And Interpretation Per Extremity; Using Cooling Stimuli To Assess Small Nerve Fiber Sensation And Hyperalgesia	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0109T	Quantitative Sensory Testing (Qst) Testing And Interpretation Per Extremity; Using Heat-Pain Stimuli To Assess Small Nerve Fiber Sensation And Hyperalgesia	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0110T	Quantitative Sensory Testing (Qst) Testing And Interpretation Per Extremity; Using Other Stimuli To Assess Sensation	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0175T	Computer-Aided Detection (Cad) (Computer Algorithm Analysis Of Digital Image Data For Lesion Detection) With Further Physician Review For Interpretation And Report With Or Without Digitization Of Film Radiographic Images Chest Radiograph(S) Performed Remote From Primary Interpretation	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0184T	Excision Of Rectal Tumor Transanal Endoscopic Microsurgical Approach (Ie Tems) Including Muscularis Propria (Ie Full Thickness)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0198T	Measurement Of Ocular Blood Flow By Repetitive Intraocular Pressure Sampling With Interpretation And Report	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0200T	Percutaneous Sacral Augmentation (Sacroplasty) Unilateral Injection(S) Including The Use Of A Balloon Or Mechanical Device When Used 1 Or More Needles Includes Imaging Guidance And Bone Biopsy When Performed	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0201T	Percutaneous Sacral Augmentation (Sacroplasty) Bilateral Injections Including The Use Of A Balloon Or Mechanical Device When Used 2 Or More Needles Includes Imaging Guidance And Bone Biopsy When Performed	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

0202T	Posterior Vertebral Joint(S) Arthroplasty (Eg Facet Joint[S] Replacement) Including Facetectomy Laminectomy Foraminotomy And Vertebral Column Fixation Injection Of Bone Cement When Performed Including Fluoroscopy Single Level Lumbar Spine	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0207T	Evacuation Of Meibomian Glands Automated Using Heat And Intermittent Pressure 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).	_	_	_
0208T	Pure Tone Audiometry (Threshold) Automated; Air Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0209T	Pure Tone Audiometry (Threshold) Automated; Air And Bone	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0210T	Speech Audiometry Threshold Automated;	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0211T	Speech Audiometry Threshold Automated; With Speech Recognition	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0219T	Placement Of A Posterior Intrafacet Implant(S) Unilateral Or Bilateral Including Imaging And Placement Of Bone Graft(S) Or Synthetic Device(S) Single Level; 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).	_	_	_
0220T	Placement Of A Posterior Intrafacet Implant(S) Unilateral Or Bilateral Including Imaging And Placement Of Bone Graft(S) Or Synthetic Device(S) Single Level; Thoracic	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0221T	Placement Of A Posterior Intrafacet Implant(S) Unilateral Or Bilateral Including Imaging And Placement Of Bone Graft(S) Or Synthetic Device(S) Single Level; 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).	_	_	_
0222T	Placement Of A Posterior Intrafacet Implant(S) Unilateral Or Bilateral Including Imaging And Placement Of Bone Graft(S) Or Synthetic Device(S) Single Level; Each Additional Vertebral Segment (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_

0224U	Antibody Severe Acute Respiratory Syndrome Coronavirus 2 (Sars-Cov-2) (Coronavirus Disease [Covid-19]) Includes Titer(S) When Performed	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0226U	Surrogate Viral Neutralization Test (Svnt) Severe Acute Respiratory Syndrome Coronavirus 2 (Sars-Cov-2) (Coronavirus Disease [Covid-19]) Elisa Plasma Seru	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0232T	Injection(S) Platelet Rich Plasma Any Site Including Image Guidance Harvesting And Preparation When Performed	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0253T	Insertion Of Anterior Segment Aqueous Drainage Device Without Extraocular Reservoir Internal Approach Into The Suprachoroidal Space	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0263T	Intramuscular Autologous Bone Marrow Cell Therapy With Preparation Of Harvested Cells Multiple Injections One Leg Including Ultrasound Guidance If Performed; Complete Procedure Including Unilateral Or Bilateral Bone Marrow Harvest	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0264T	Intramuscular Autologous Bone Marrow Cell Therapy With Preparation Of Harvested Cells Multiple Injections One Leg Including Ultrasound Guidance If Performed; Complete Procedure Excluding Bone Marrow Harvest	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0265T	Intramuscular Autologous Bone Marrow Cell Therapy With Preparation Of Harvested Cells Multiple Injections One Leg Including Ultrasound Guidance If Performed; Unilateral Or Bilateral Bone Marrow Harvest Only For Intramuscular Autologous Bone Marrow Cell Therapy	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0266T	Implantation Or Replacement Of Carotid Sinus Baroreflex Activation Device; Total System (Includes Generator Placement Unilateral Or Bilateral Lead Placement Intra-Operative Interrogation Programming And Repositioning When Performed)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0267T	Implantation Or Replacement Of Carotid Sinus Baroreflex Activation Device; Lead Only Unilateral (Includes Intra-Operative Interrogation Programming And Repositioning When Performed)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0268T	Implantation Or Replacement Of Carotid Sinus Baroreflex Activation Device; Pulse Generator Only (Includes Intra-Operative Interrogation Programming And Repositioning When Performed)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

0269T	Revision Or Removal Of Carotid Sinus Baroreflex Activation Device; Total System (Includes Generator Placement Unilateral Or Bilateral Lead Placement Intra-Operative Interrogation Programming And Repositioning When Performed)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0270T	Revision Or Removal Of Carotid Sinus Baroreflex Activation Device; Lead Only Unilateral (Includes Intra-Operative Interrogation Programming And Repositioning When Performed)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0271T	Revision Or Removal Of Carotid Sinus Baroreflex Activation Device; Pulse Generator Only (Includes Intra-Operative Interrogation Programming And Repositioning When Performed)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0272T	Interrogation Device Evaluation (In Person) Carotid Sinus Baroreflex Activation System Including Telemetric Iterative Communication With The Implantable Device To Monitor Device Diagnostics And Programmed Therapy Values With Interpretation And Report (Eg Battery Status Lead Impedance Pulse Amplitude Pulse Width Therapy Frequency Pathway Mode Burst Mode Therapy Start/Stop Times Each Day);	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0273T	Interrogation Device Evaluation (In Person) Carotid Sinus Baroreflex Activation System Including Telemetric Iterative Communication With The Implantable Device To Monitor Device Diagnostics And Programmed Therapy Values With Interpretation And Report (Eg Battery Status Lead Impedance Pulse Amplitude Pulse Width Therapy Frequency Pathway Mode Burst Mode Therapy Start/Stop Times Each Day); With Programming	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0274T	Percutaneous Laminotomy/Laminectomy (Interlaminar Approach) For Decompression Of Neural Elements (With Or Without Ligamentous Resection Discectomy Facetectomy And/Or Foraminotomy) Any Method Under Indirect Image Guidance (Eg Fluoroscopic Ct) Single Or Multiple Levels Unilateral Or Bilateral; Cervical Or Thoracic	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0275T	Percutaneous Laminotomy/Laminectomy (Interlaminar Approach) For Decompression Of Neural Elements (With Or Without Ligamentous Resection Discectomy Facetectomy And/Or Foraminotomy) Any Method Under Indirect Image Guidance (Eg Fluoroscopic Ct) Single Or Multiple Levels Unilateral Or Bilateral; Lumbar	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_

0278T	Transcutaneous Electrical Modulation Pain Reprocessing (Eg Scrambler Therapy) Each Treatment Session (Includes Placement Of Electrodes)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0308T	Insertion Of Ocular Telescope Prosthesis Including Removal Of Crystalline Lens Or Intraocular Lens Prosthesis	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0322U	Neurology (Autism Spectrum Disorder [Asd]) Quantitative Measurements Of 14 Acyl Carnitines And Microbiome-Derived Metabolites Liquid Chromatography With Tandem Mass Spectrometry (Lc-Ms/Ms) Plasma Results Reported As Negative Or Positive For Risk Of Metabolic Subtypes Associated With Asd	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	1/14/2024	Add effective 10/15/2023 retire effective 01/14/2024
0322U	Neurology (Autism Spectrum Disorder [Asd]) Quantitative Measurements Of 14 Acyl Carnitines And Microbiome-Derived Metabolites Liquid Chromatography With Tandem Mass Spectrometry (Lc-Ms/Ms) Plasma Results Reported As Negative Or Positive For Risk Of Metabolic Subtypes Associated With Asd	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	1/15/2024	_	Add effective 1/15/2024
0323U	Infectious Agent Detection By Nucleic Acid (Dna And Rna) Central Nervous System Pathogen Metagenomic Next-Generation Sequencing Cerebrospinal Fluid (Csf) Identification Of Pathogenic Bacteria Viruses Parasites Or Fungi	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0329T	Monitoring Of Intraocular Pressure For 24 Hours Or Longer Unilateral Or Bilateral With Interpretation And Report	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0330T	Tear Film Imaging Unilateral Or Bilateral With Interpretation And Report	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0331T	Myocardial Sympathetic Innervation Imaging Planar Qualitative And Quantitative Assessment;	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0332T	Myocardial Sympathetic Innervation Imaging Planar Qualitative And Quantitative Assessment; With Tomographic Spect	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

0332U	Oncology (Pan-Tumor) Genetic Profiling Of 8 Dna-Regulatory (Epigenetic) Markers By Quantitative Polymerase Chain Reaction (Qpcr) Whole Blood Reported As A High Or Low Probability Of Responding To Immune Checkpoint–Inhibitor Therapy	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	3/31/2024	Retire effective 03/31/2024
0333U	Oncology (Liver) Surveillance For Hepatocellular Carcinoma (Hcc) In Highrisk Patients Analysis Of Methylation Patterns On Circulating Cell-Free Dna (Cfdna) Plus Measurement Of Serum Of Afp/Afp-L3 And Oncoprotein Des-Gammacarboxy-Prothrombin (Dcp) Algorithm Reported As Normal Or Abnormal Result	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	3/31/2024	Retire effective 03/31/2024
0334U	Oncology (Solid Organ) Targeted Genomic Sequence Analysis Formalin-Fixed Paraffinembedded (Ffpe) Tumor Tissue Dna Analysis 84 Or More Genes Interrogation For Sequence Variants Gene Copy Number Amplifications Gene Rearrangements Microsatellite Instability And Tumor Mutational Burden	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	3/31/2024	Retire effective 03/31/2024
0335T	Insertion Of Sinus Tarsi Implant	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0335U	Rare Diseases (Constitutional/Heritable Disorders) Whole Genome Sequence Analysis Including Small Sequence Changes Copy Number Variants Deletions Duplications Mobile Element Insertions Uniparental Disomy (Upd) Inversions Aneuploidy Mitochondrial Genome Sequence Analysis With Heteroplasmy And Large Deletions Short Tandem Repeat (Str) Gene Expansions Fetal Sample Identification And Categorization Of Genetic Variants	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	3/31/2024	Retire effective 03/31/2024
0336U	Rare Diseases (Constitutional/Heritable Disorders) Whole Genome Sequence Analysis Including Small Sequence Changes Copy Number Variants Deletions Duplications Mobile Element Insertions Uniparental Disomy (Upd) Inversions Aneuploidy Mitochondrial Genome Sequence Analysis With Heteroplasmy And Large Deletions Short Tandem Repeat (Str) Gene Expansions Blood Or Saliva Identification And Categorization Of Genetic Variants Each Comparator Genome (Eg Parent)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	3/31/2024	Retire effective 03/31/2024
0337U	Oncology (Plasma Cell Disorders And Myeloma) Circulating Plasma Cell Immunologic Selection Identification Morphological Characterization And Enumeration Of Plasma Cells Based On Differential Cd138 Cd38 Cd19 And Cd45 Protein Biomarker Expression Peripheral Blood	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

0338T	Transcatheter Renal Sympathetic Denervation Percutaneous Approach Including Arterial Puncture Selective Catheter Placement(S) Renal Artery(Ies) Fluoroscopy Contrast Injection(S) Intraprocedural Roadmapping And Radiological Supervision And Interpretation Including Pressure Gradient Measurements Flush Aortogram And Diagnostic Renal Angiography When Performed; 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).	_	_	_
0338U	Oncology (Solid Tumor) Circulating Tumor Cell Selection Identification Morphological Characterization Detection And Enumeration Based On Differential Epcam Cytokeratins 8 18 And 19 And Cd45 Protein Biomarkers And Quantification Of Her2 Protein Biomarker–Expressing Cells Peripheral Blood	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0339T	Transcatheter Renal Sympathetic Denervation Percutaneous Approach Including Arterial Puncture Selective Catheter Placement(S) Renal Artery(Ies) Fluoroscopy Contrast Injection(S) Intraprocedural Roadmapping And Radiological Supervision And Interpretation Including Pressure Gradient Measurements Flush Aortogram And Diagnostic Renal Angiography When Performed; 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).	_	_	_
0339U	Oncology (Prostate) Mrna Expression Profiling Of Hoxc6 And Dlx1 Reverse Transcription Polymerase Chain Reaction (Rt-Pcr) First-Void Urine Following Digital Rectal Examination Algorithm Reported As Probability Of High-Grade Cancer	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	3/31/2024	Retire effective 03/31/2024
0340U	Oncology (Pan-Cancer) Analysis Of Minimal Residual Disease (Mrd) From Plasma With Assays Personalized To Each Patient Based On Prior Next-Generation Sequencing Of The Patient'S Tumor And Germline Dna Reported As Absence Or Presence Of Mrd With Disease-Burden Correlation If Appropriate	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	3/31/2024	Retire effective 03/31/2024
0341U	Fetal Aneuploidy Dna Sequencing Comparative Analysis Fetal Dna From Products Of Conception Reported As Normal (Euploidy) Monosomy Trisomy Or Partial Deletion/Duplication Mosaicism And Segmental Aneuploid	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	3/31/2024	Retire effective 03/31/2024
0342T	Therapeutic Apheresis With Selective Hdl Delipidation And Plasma Reinfusion	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

0342U	Oncology (Pancreatic Cancer) Multiplex Immunoassay Of C5 C4 Cystatin C Factor B Osteoprotegerin (Opg) Gelsolin Igfbp3 Ca125 And Multiplex Electrochemiluminescent Immunoassay (Eclia) For Ca19-9 Serum Diagnostic Algorithm Reported Qualitatively As Positive Negative Or Borderline	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0343U	Oncology (Prostate) Exosome-Based Analysis Of 442 Small Noncoding Rnas (Sncrnas) By Quantitative Reverse Transcription Polymerase Chain Reaction (Rt-Qpcr) Urine Reported As Molecular Evidence Of No- Low- Intermediate- Or High-Risk Of Prostate Cancer	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	3/31/2024	Retire effective 03/31/2024
0344U	Hepatology (Nonalcoholic Fatty Liver Disease [Nafld]) Semiquantitative Evaluation Of 28 Lipid Markers By Liquid Chromatography With Tandem Mass Spectrometry (Lc-Ms/Ms) Serum Reported As At-Risk For Nonalcoholic Steatohepatitis (Nash) Or Not Nash	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0345T	Transcatheter Mitral Valve Repair Percutaneous Approach Via The Coronary Sinus	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0345U	Psychiatry (Eg Depression Anxiety Attention Deficit Hyperactivity Disorder [Adhd]) Genomic Analysis Panel Variant Analysis Of 15 Genes Including Deletion/Duplication Analysis Of Cyp2D6	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	3/31/2024	Retire effective 03/31/2024
0346U	Beta Amyloid A?40 And A?42 By Liquid Chromatography With Tandem Mass Spectrometry (Lc-Ms/Ms) Ratio Plasma	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0347T	Placement Of Interstitial Device(S) In Bone For Radiostereometric Analysis (Rsa)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0347U	Drug Metabolism Or Processing (Multiple Conditions) Whole Blood Or Buccal Specimen Dna Analysis 16 Gene Report With Variant Analysis And Reported Phenotypes	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	3/31/2024	Retire effective 03/31/2024
0348T	Radiologic Examination Radiostereometric Analysis (Rsa); Spine (Includes Cervical Thoracic And Lumbosacral When Performed)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_

0348U	Drug Metabolism Or Processing (Multiple Conditions) Whole Blood Or Buccal Specimen Dna Analysis 25 Gene Report With Variant Analysis And Reported Phenotypes	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	3/31/2024	Retire effective 03/31/2024
0349T	Radiologic Examination Radiostereometric Analysis (Rsa); Upper Extremity(Ies) (Includes Shoulder Elbow And Wrist When Performed)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0349U	Drug Metabolism Or Processing (Multiple Conditions) Whole Blood Or Buccal Specimen Dna Analysis 27 Gene Report With Variant Analysis Including Reported Phenotypes And Impacted Gene-Drug Interactions	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	3/31/2024	Retire effective 03/31/2024
0350T	Radiologic Examination Radiostereometric Analysis (Rsa); Lower Extremity(Ies) (Includes Hip Proximal Femur Knee And Ankle When Performed)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0350U	Drug Metabolism Or Processing (Multiple Conditions) Whole Blood Or Buccal Specimen Dna Analysis 27 Gene Report With Variant Analysis And Reported Phenotypes	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	3/31/2024	Retire effective 03/31/2024
0351T	Optical Coherence Tomography Of Breast Or Axillary Lymph Node Excised Tissue Each Specimen; Real-Time Intraoperative	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0351U	Infectious Disease (Bacterial Or Viral) Biochemical Assays Tumor Necrosis Factor-Related Apoptosisinducing Ligand (Trail) Interferon Gamma-Induced Protein-10 (Ip-10) And C-Reactive Protein Serum Or Venous Whole Blood Algorithm Reported As Likelihood Of Bacterial Infection	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0352T	Optical Coherence Tomography Of Breast Or Axillary Lymph Node Excised Tissue Each Specimen; Interpretation And Report Real-Time Or Referred	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0353T	Optical Coherence Tomography Of Breast Surgical Cavity; Real-Time Intraoperative	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

0353U	Infectious Agent Detection By Nucleic Acid (Dna) Chlamydia Trachomatis And Neisseria Gonorrhoeae Multiplex Amplified Probe Technique Urine Vaginal Pharyngeal Or Rectal Each Pathogen Reported As Detected Or Not Detected	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	1/1/2024	Retire effective 1/1/2024
0354U	Human papilloma virus (HPV), high-risk types (ie, 16, 18, 31, 33, 45, 52 and 58) qualitative mRNA expression of E6/E7 by quantitative polymerase chain reaction (qPCR)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	3/31/2024	Retire effective 03/31/2024
0358T	Bioelectrical Impedance Analysis Whole Body Composition Assessment With Interpretation And Report	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0368U	Oncology (Colorectal Cancer) Evaluation For Mutations Of Apc Braf Ctnnb1 Kras Nras Pik3Ca Smad4 And Tp53 And Methylation Markers (Myo1G Kcnq5 C9Orf50 Fli1 Clip4 Znf132 And Twist1) Multiplex Quantitative Polymerase Chain Reaction (Qpcr) Circulating Cell-Free Dna (Cfdna) Plasma Report Of Risk Score For Advanced Adenoma Or Colorectal Cancer	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	3/31/2024	Retire effective 03/31/2024
0369U	Infectious Agent Detection By Nucleic Acid (Dna And Rna) Gastrointestinal Pathogens 31 Bacterial Viral And Parasitic Organisms And Identification Of 21 Associated Antibiotic-Resistance Genes Multiplex Amplified Probe Technique	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	5/14/2024	Retire effective 05/14/2024
0369U	Infectious Agent Detection By Nucleic Acid (Dna And Rna) Gastrointestinal Pathogens 31 Bacterial Viral And Parasitic Organisms And Identification Of 21 Associated Antibiotic-Resistance Genes Multiplex Amplified Probe Technique	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	5/15/2024	_	Add effective 05/15/2024
0375U	Oncology (Ovarian) Biochemical Assays Of 7 Proteins (Follicle Stimulating Hormone Human Epididymis Protein 4 Apolipoprotein A-1 Transferrin Beta-2 Macroglobulin Prealbumin [Ie Transthyretin] And Cancer Antigen 125) Algorithm Reported As Ovarian Cancer Risk Score	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0378T	Visual Field Assessment With Concurrent Real Time Data Analysis And Accessible Data Storage With Patient Initiated Data Transmitted To A Remote Surveillance Center For Up To 30 Days; Review And Interpretation With Report By A Physician Or Other Qualified Health Care Professional	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_

0379T	Visual Field Assessment With Concurrent Real Time Data Analysis And Accessible Data Storage With Patient Initiated Data Transmitted To A Remote Surveillance Center For Up To 30 Days; Technical Support And Patient Instructions Surveillance Analysis And Transmission Of Daily And Emergent Data Reports As Prescribed By A Physician Or Other Qualified Health Care Professional	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0397T	Endoscopic Retrograde Cholangiopancreatography (Ercp) With Optical Endomicroscopy (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0398T	Magnetic Resonance Image Guided High Intensity Focused Ultrasound (Mrgfus) Stereotactic Ablation Lesion Intracranial For Movement Disorder Including Stereotactic Navigation And Frame Placement When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0402T	Collagen Cross-Linking Of Cornea Including Removal Of The Corneal Epithelium When Performed And Intraoperative Pachymetry When Performed	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0408T	Insertion Or Replacement Of Permanent Cardiac Contractility Modulation System Including Contractility Evaluation When Performed And Programming Of Sensing And Therapeutic Parameters; Pulse Generator With Transvenous Electrodes	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0409T	Insertion Or Replacement Of Permanent Cardiac Contractility Modulation System Including Contractility Evaluation When Performed And Programming Of Sensing And Therapeutic Parameters; Pulse Generator Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0410T	Insertion Or Replacement Of Permanent Cardiac Contractility Modulation System Including Contractility Evaluation When Performed And Programming Of Sensing And Therapeutic Parameters; Atrial Electrode Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0411T	Insertion Or Replacement Of Permanent Cardiac Contractility Modulation System Including Contractility Evaluation When Performed And Programming Of Sensing And Therapeutic Parameters; Ventricular Electrode Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0412T	Removal Of Permanent Cardiac Contractility Modulation System; Pulse Generator Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

0413T	Removal Of Permanent Cardiac Contractility Modulation System; Transvenous Electrode (Atrial Or Ventricular)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0414T	Removal And Replacement Of Permanent Cardiac Contractility Modulation System Pulse Generator Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0415T	Repositioning Of Previously Implanted Cardiac Contractility Modulation Transvenous Electrode (Atrial Or Ventricular Lead)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0416T	Relocation Of Skin Pocket For Implanted Cardiac Contractility Modulation Pulse Generator	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0417T	Programming Device Evaluation (In Person) With Iterative Adjustment Of The Implantable Device To Test The Function Of The Device And Select Optimal Permanent Programmed Values With Analysis Including Review And Report Implantable Cardiac Contractility Modulation System	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0418T	Interrogation Device Evaluation (In Person) With Analysis Review And Report Includes Connection Recording And Disconnection Per Patient Encounter Implantable Cardiac Contractility Modulation System	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0419T	Destruction Of Neurofibroma Extensive (Cutaneous Dermal Extending Into Subcutaneous); Face Head And Neck Greater Than 50 Neurofibromas	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0420T	Destruction Of Neurofibroma Extensive (Cutaneous Dermal Extending Into Subcutaneous); Trunk And Extremities Extensive Greater Than 100 Neurofibromas	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0421U	Oncology (Colorectal) Screening Quantitative Real-Time Target And Signal Amplification Of 8 Rna Markers (Gapdh Smad4 Acy1 Areg Cdh1 Kras Tnfrsf10B Egln2) And Fecal Hemoglobin Algorithm Reported As A Positive Or Negative For Colorectal Cancer Risk	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024

0422T	Tactile Breast Imaging By Computer-Aided Tactile Sensors Unilateral Or Bilateral	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0422U	Oncology (Pan-Solid Tumor) Analysis Of Dna Biomarker Response To Anti-Cancer Therapy Using Cell-Free Circulating Dna Biomarker Comparison To A Previous Baseline Pre-Treatment Cell-Free Circulating Dna Analysis Using Next-Generation Sequencing Algorithm Reported As A Quantitative Change From Baseline Including Specific Alterations If Appropriate	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	3/31/2024	Add effective 01/01/2024 Retire effective 03/31/2024
0423U	Psychiatry (Eg Depression Anxiety) Genomic Analysis Panel Including Variant Analysis Of 26 Genes Buccal Swab Report Including Metabolizer Status And Risk Of Drug Toxicity By Condition	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	3/31/2024	Add effective 01/01/2024 Retire effective 03/31/2024
0425U	Genome (Eg Unexplained Constitutional Or Heritable Disorder Or Syndrome) Rapid Sequence Analysis Each Comparator Genome (Eg Parents Siblings)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	3/31/2024	Add effective 01/01/2024 Retire effective 03/31/2024
0426U	Genome (Eg Unexplained Constitutional Or Heritable Disorder Or Syndrome) Ultra-Rapid Sequence Analysis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	3/31/2024	Add effective 01/01/2024 Retire effective 03/31/2024
0428U	Oncology (Breast) Targeted Hybrid-Capture Genomic Sequence Analysis Panel Circulating Tumor Dna (Ctdna) Analysis Of 56 Or More Genes Interrogation For Sequence Variants Gene Copy Number Amplifications Gene Rearrangements Microsatellite Instability And Tumor Mutation Burden	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	3/31/2024	Add effective 01/01/2024 Retire effective 03/31/2024
0434U	Drug Metabolism (Adverse Drug Reactions And Drug Response) Genomic Analysis Panel Variant Analysis Of 25 Genes With Reported Phenotypes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	3/31/2024	Add effective 01/01/2024 Retire effective 03/31/2024
0436U	Oncology (Lung) Plasma Analysis Of 388 Proteins Using Aptamerbased Proteomics Technology Predictive Algorithm Reported As Clinical Benefit From Immune Checkpoint Inhibitor Therapy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
0437U	Psychiatry (Anxiety Disorders) Mrna Gene Expression Profiling By Rna Sequencing Of 15 Biomarkers Whole Blood Algorithm Reported As Predictive Risk Score	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	3/31/2024	Add effective 01/01/2024 Retire effective 03/31/2024
0438U	Drug Metabolism (Adverse Drug Reactions And Drug Response) Buccal Specimen Gene-Drug Interactions Variant Analysis Of 33 Genes Including Deletion/Duplication Analysis Of Cyp2D6 Including Reported Phenotypes And Impacted Genedrug Interactions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	3/31/2024	Add effective 01/01/2024 Retire effective 03/31/2024

0440T	Ablation Percutaneous Cryoablation Includes Imaging Guidance; Upper Extremity Distal/Peripheral Nerve	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0441T	Ablation Percutaneous Cryoablation Includes Imaging Guidance; Lower Extremity Distal/Peripheral Nerve	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0442T	Ablation Percutaneous Cryoablation Includes Imaging Guidance; Nerve Plexus Or Other Truncal Nerve (Eg Brachial Plexus Pudendal Nerve)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0443T	Real-Time Spectral Analysis Of Prostate Tissue By Fluorescence Spectroscopy Including Imaging Guidance (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0444U	Oncology (Solid Organ Neoplasia) Targeted Genomic Sequence Analysis Panel Of 361 Genes Interrogation For Gene Fusions Translocations Or Other Rearrangements Using Dna From Formalin-Fixed Paraffin-Embedded (Ffpe) Tumor Tissue Report Of Clinically Significant Variant(S)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2024	_	Add effective 4/1/2024
0446U	Autoimmune Diseases (Systemic Lupus Erythematosus [Sle]) Analysis Of 10 Cytokine Soluble Mediator Biomarkers By Immunoassay Plasma Individual Components Reported With An Algorithmic Risk Score For Current Disease Activity	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2024	_	Add effective 4/1/2024
0447U	Autoimmune Diseases (Systemic Lupus Erythematosus [Sle]) Analysis Of 11 Cytokine Soluble Mediator Biomarkers By Immunoassay Plasma Individual Components Reported With An Algorithmic Prognostic Risk Score For Developing A Clinical Flare	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2024	_	Add effective 4/1/2024
0448U	Oncology (Lung And Colon Cancer) Dna Qualitative Nextgeneration Sequencing Detection Of Single-Nucleotide Variants And Deletions In Egfr And Kras Genes Formalin-Fixed Paraffinembedded (Ffpe) Solid Tumor Samples Reported As Presence Or Absence Of Targeted Mutation(S) With Recommended Therapeutic Options	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2024	_	Add effective 4/1/2024
0449T	Insertion Of Aqueous Drainage Device Without Extraocular Reservoir Internal Approach Into The Subconjunctival Space; Initial Device	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

0449U	Carrier Screening For Severe Inherited Conditions (Eg Cystic Fibrosis Spinal Muscular Atrophy Beta Hemoglobinopathies [Including Sickle Cell Disease] Alpha Thalassemia) Regardless Of Race Or Self-Identified Ancestry Genomic Sequence Analysis Panel Must Include Analysis Of 5 Genes (Cftr Smn1 Hbb Hba1 Hba2)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2024	_	Add effective 4/1/2024
0450T	Insertion Of Aqueous Drainage Device Without Extraocular Reservoir Internal Approach Into The Subconjunctival Space; Each Additional Device (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0464T	Visual Evoked Potential Testing For Glaucoma With Interpretation And Report	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0472T	Device Evaluation Interrogation And Initial Programming Of Intraocular Retinal Electrode Array (Eg Retinal Prosthesis) In Person With Iterative Adjustment Of The Implantable Device To Test Functionality Select Optimal Permanent Programmed Values With Analysis Including Visual Training With Review And Report By A Qualified Health Care Professional	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0473T	Device Evaluation And Interrogation Of Intraocular Retinal Electrode Array (Eg Retinal Prosthesis) In Person Including Reprogramming And Visual Training When Performed With Review And Report By A Qualified Health Care Professional	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0474T	Insertion Of Anterior Segment Aqueous Drainage Device With Creation Of Intraocular Reservoir Internal Approach Into The Supraciliary Space	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0481T	Injection(S) Autologous White Blood Cell Concentrate (Autologous Protein Solution) Any Site Including Image Guidance Harvesting And Preparation When Performed	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0483T	Transcatheter Mitral Valve Implantation/Replacement (Tmvi) With Prosthetic Valve; Percutaneous Approach Including Transseptal Puncture When Performed	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

0484T	Transcatheter Mitral Valve Implantation/Replacement (Tmvi) With Prosthetic Valve; Transthoracic Exposure (Eg Thoracotomy Transapical)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0485T	Optical Coherence Tomography (Oct) Of Middle Ear With Interpretation And Report; Unilateral	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0486T	Optical Coherence Tomography (Oct) Of Middle Ear With Interpretation And Report; Bilateral	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0489T	Autologous Adipose-Derived Regenerative Cell Therapy For Scleroderma In The Hands; Adipose Tissue Harvesting Isolation And Preparation Of Harvested Cells Including Incubation With Cell Dissociation Enzymes Removal Of Non-Viable Cells And Debris Determination Of Concentration And Dilution Of Regenerative Cells	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0490T	Autologous Adipose-Derived Regenerative Cell Therapy For Scleroderma In The Hands; Multiple Injections In One Or Both Hands	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0494T	Surgical Preparation And Cannulation Of Marginal (Extended) Cadaver Donor Lung(S) To Ex Vivo Organ Perfusion System Including Decannulation Separation From The Perfusion System And Cold Preservation Of The Allograft Prior To Implantation When Performed	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0495T	Initiation And Monitoring Marginal (Extended) Cadaver Donor Lung(S) Organ Perfusion System By Physician Or Qualified Health Care Professional Including Physiological And Laboratory Assessment (Eg Pulmonary Artery Flow Pulmonary Artery Pressure Left Atrial Pressure Pulmonary Vascular Resistance Mean/Peak And Plateau Airway Pressure Dynamic Compliance And Perfusate Gas Analysis) Including Bronchoscopy And X Ray When Performed; First Two Hours In Sterile Field	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

0496T	Initiation And Monitoring Marginal (Extended) Cadaver Donor Lung(S) Organ Perfusion System By Physician Or Qualified Health Care Professional Including Physiological And Laboratory Assessment (Eg Pulmonary Artery Flow Pulmonary Artery Pressure Left Atrial Pressure Pulmonary Vascular Resistance Mean/Peak And Plateau Airway Pressure Dynamic Compliance And Perfusate Gas Analysis) Including Bronchoscopy And X Ray When Performed; Each Additional Hour (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0507T	Near Infrared Dual Imaging (Ie Simultaneous Reflective And Transilluminated Light) Of Meibomian Glands Unilateral Or Bilateral With Interpretation And Report	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0509T	Electroretinography (Erg) With Interpretation And Report Pattern (Perg)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0510T	Removal Of Sinus Tarsi Implant	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0511T	Removal And Reinsertion Of 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).	_	_	_
0512T	Extracorporeal Shock Wave For Integumentary Wound Healing Including Topical Application And Dressing Care; Initial Wound	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0513T	Extracorporeal Shock Wave For Integumentary Wound Healing Including Topical Application And Dressing Care; Each Additional Wound (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0515T	Insertion Of Wireless Cardiac Stimulator For Left Ventricular Pacing Including Device Interrogation And Programming And Imaging Supervision And Interpretation When Performed; Complete System (Includes Electrode And Generator [Transmitter And Battery])	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0516T	Insertion Of Wireless Cardiac Stimulator For Left Ventricular Pacing Including Device Interrogation And Programming And Imaging Supervision And Interpretation When Performed; Electrode Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

0517T	Insertion Of Wireless Cardiac Stimulator For Left Ventricular Pacing Including Device Interrogation And Programming And Imaging Supervision And Interpretation When Performed; Both Components Of Pulse Generator (Battery And Transmitter) Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0518T	Removal Of Pulse Generator For Wireless Cardiac Stimulator For Left Ventricular Pacing; Battery Component Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0519T	Removal And Replacement Of Pulse Generator For Wireless Cardiac Stimulator For Left Ventricular Pacing Including Device Interrogation And Programming; Both Components (Battery And Transmitter)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0520T	Removal And Replacement Of Pulse Generator For Wireless Cardiac Stimulator For Left Ventricular Pacing Including Device Interrogation And Programming; Battery Component Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0521T	Interrogation Device Evaluation (In Person) With Analysis Review And Report Includes Connection Recording And Disconnection Per Patient Encounter Wireless Cardiac Stimulator For Left Ventricular Pacing	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0522T	Programming Device Evaluation (In Person) With Iterative Adjustment Of The Implantable Device To Test The Function Of The Device And Select Optimal Permanent Programmed Values With Analysis Including Review And Report Wireless Cardiac Stimulator For Left Ventricular Pacing	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0524T	Endovenous Catheter Directed Chemical Ablation With Balloon Isolation Of Incompetent Extremity Vein Open Or Percutaneous Including All Vascular Access Catheter Manipulation Diagnostic Imaging Imaging Guidance And Monitoring	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0525T	Insertion Or Replacement Of Intracardiac Ischemia Monitoring System Including Testing Of The Lead And Monitor Initial System Programming And Imaging Supervision And Interpretation; Complete System (Electrode And Implantable Monitor)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0526T	Insertion Or Replacement Of Intracardiac Ischemia Monitoring System Including Testing Of The Lead And Monitor Initial System Programming And Imaging Supervision And Interpretation; Electrode Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

0527T	Insertion Or Replacement Of Intracardiac Ischemia Monitoring System Including Testing Of The Lead And Monitor Initial System Programming And Imaging Supervision And Interpretation; Implantable Monitor Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0528T	Programming Device Evaluation (In Person) Of Intracardiac Ischemia Monitoring System With Iterative Adjustment Of Programmed Values With Analysis Review And Report	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0529T	Interrogation Device Evaluation (In Person) Of Intracardiac Ischemia Monitoring System With Analysis Review And Report	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0530T	Removal Of Intracardiac Ischemia Monitoring System Including All Imaging Supervision And Interpretation; Complete System (Electrode And Implantable Monitor)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0531T	Removal Of Intracardiac Ischemia Monitoring System Including All Imaging Supervision And Interpretation; Electrode Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0532T	Removal Of Intracardiac Ischemia Monitoring System Including All Imaging Supervision And Interpretation; Implantable Monitor Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0537T	Chimeric Antigen Receptor T-Cell (Car-T) Therapy; Harvesting Of Blood-Derived T Lymphocytes For Development Of Genetically Modified Autologous Car-T Cells Per Day	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0538T	Chimeric Antigen Receptor T-Cell (Car-T) Therapy; Preparation Of Blood-Derived T Lymphocytes For Transportation (Eg Cryopreservation Storage)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0539T	Chimeric Antigen Receptor T-Cell (Car-T) Therapy; Receipt And Preparation Of Car-T Cells For Administration	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

0540T	Chimeric Antigen Receptor T-Cell (Car-T) Therapy; Car-T Cell Administration Autologous	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0544T	Transcatheter Mitral Valve Annulus Reconstruction With Implantation Of Adjustable Annulus Reconstruction Device Percutaneous Approach Including Transseptal Puncture	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0546T	Radiofrequency Spectroscopy Real Time Intraoperative Margin Assessment At The Time Of Partial Mastectomy With Report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
0547T	Bone-Material Quality Testing By Microindentation(S) Of The Tibia(S) With Results Reported As A Score	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
0552T	Low-Level Laser Therapy Dynamic Photonic And Dynamic Thermokinetic Energies Provided By A Physician Or Other Qualified Health Care Professional	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0563T	Evacuation Of Meibomian Glands Using Heat Delivered Through Wearable Open-Eye Eyelid Treatment Devices And Manual Gland Expression 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).	_	_	_
0565T	Autologous Cellular Implant Derived From Adipose Tissue For The Treatment Of Osteoarthritis Of The Knees; Tissue Harvesting And Cellular Implant Creation	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0566T	Autologous Cellular Implant Derived From Adipose Tissue For The Treatment Of Osteoarthritis Of The Knees; Injection Of Cellular Implant Into Knee Joint Including Ultrasound Guidance 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).	_	_	_
0569T	Transcatheter Tricuspid Valve Repair Percutaneous Approach; Initial Prosthesis	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0570T	Transcatheter Tricuspid Valve Repair Percutaneous Approach; Each Additional Prosthesis During Same Session (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0587T	Percutaneous Implantation Or Replacement Of Integrated Single Device Neurostimulation System For Bladder Dysfunction Including Electrode Array And Receiver Or Pulse Generator Including Analysis Programming And Imaging Guidance When Performed Posterior Tibial Nerve	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

0588T	Revision Or Removal Of Percutaneously Placed Integrated Single Device Neurostimulation System For Bladder Dysfunction Including Electrode Array And Receiver Or Pulse Generator Including Analysis Programming And Imaging Guidance When Performed Posterior Tibial Nerve	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0589T	Electronic Analysis With Simple Programming Of Implanted Integrated Neurostimulation System For Bladder Dysfunction (Eg Electrode Array And Receiver) Including Contact Group(S) Amplitude Pulse Width Frequency (Hz) On/Off Cycling Burst Dose Lockout Patient-Selectable Parameters Responsive Neurostimulation Detection Algorithms Closed-Loop Parameters And Passive Parameters When Performed By Physician Or Other Qualified Health Care Professional Posterior Tibial Nerve 1-3 Parameters	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0590T	Electronic Analysis With Complex Programming Of Implanted Integrated Neurostimulation System For Bladder Dysfunction (Eg Electrode Array And Receiver) Including Contact Group(S) Amplitude Pulse Width Frequency (Hz) On/Off Cycling Burst Dose Lockout Patient-Selectable Parameters Responsive Neurostimulation Detection Algorithms Closed-Loop Parameters And Passive Parameters When Performed By Physician Or Other Qualified Health Care Professional Posterior Tibial Nerve 4 Or More Parameters	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0596T	Temporary Female Intraurethral Valve-Pump (Ie Voiding Prosthesis); Initial Insertion Including Urethral Measurement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0597T	Temporary Female Intraurethral Valve-Pump (Ie Voiding Prosthesis); Replacement	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0600T	Ablation Irreversible Electroporation; 1 Or More Tumors Per Organ Including Imaging Guidance When Performed Percutaneous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0601T	Ablation Irreversible Electroporation; 1 Or More Tumors Per Organ Including Fluoroscopic And Ultrasound Guidance When Performed Open	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0602T	Glomerular Filtration Rate (Gfr) Measurement(S) Transdermal Including Sensor Placement And Administration Of A Single Dose Of Fluorescent Pyrazine Agent	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0603T	Glomerular Filtration Rate (Gfr) Monitoring Transdermal Including Sensor Placement And Administration Of More Than One Dose Of Fluorescent Pyrazine Agent Each 24 Hours	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_

0615T	Eye-Movement Analysis Without Spatial Calibration With Interpretation And Report	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0619T	Cystourethroscopy With Transurethral Anterior Prostate Commissurotomy And Drug Delivery Including Transrectal Ultrasound And Fluoroscopy When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	3/15/2024	6/30/2024	Add effective 03/15/2024 Retire effective 06/30/2024
0619T	Cystourethroscopy With Transurethral Anterior Prostate Commissurotomy And Drug Delivery Including Transrectal Ultrasound And Fluoroscopy When Performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
0620T	Endovascular Venous Arterialization Tibial Or Peroneal Vein With Transcatheter Placement Of Intravascular Stent Graft(S) And Closure By Any Method Including Percutaneous Or Open Vascular Access Ultrasound Guidance For Vascular Access When Performed All Catheterization(S) And Intraprocedural Roadmapping And Imaging Guidance Necessary To Complete The Intervention All Associated Radiological Supervision And Interpretation When Performed	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0621T	Trabeculostomy 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).	_	_	_
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).	_	_	_
0623T	Automated Quantification And Characterization Of Coronary Atherosclerotic Plaque To Assess Severity Of Coronary Disease Using Data From Coronary Computed Tomographic Angiography; Data Preparation And Transmission Computerized Analysis Of Data With Review Of Computerized Analysis Output To Reconcile Discordant Data Interpretation And Report	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0624T	Automated Quantification And Characterization Of Coronary Atherosclerotic Plaque To Assess Severity Of Coronary Disease Using Data From Coronary Computed Tomographic Angiography; Data Preparation And Transmission	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0625T	Automated Quantification And Characterization Of Coronary Atherosclerotic Plaque To Assess Severity Of Coronary Disease Using Data From Coronary Computed Tomographic Angiography; Computerized Analysis Of Data From Coronary Computed Tomographic Angiography	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_

0626T	Automated Quantification And Characterization Of Coronary Atherosclerotic Plaque To Assess Severity Of Coronary Disease Using Data From Coronary Computed Tomographic Angiography; Review Of Computerized Analysis Output To Reconcile Discordant Data Interpretation And Report	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0627T	Percutaneous Injection Of Allogeneic Cellular And/Or Tissue-Based Product Intervertebral Disc Unilateral Or Bilateral Injection With Fluoroscopic Guidance Lumbar; First 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).	_	_	_
0628T	Percutaneous Injection Of Allogeneic Cellular And/Or Tissue-Based Product Intervertebral Disc Unilateral Or Bilateral Injection With Fluoroscopic Guidance Lumbar; Each Additional Level (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0629T	Percutaneous Injection Of Allogeneic Cellular And/Or Tissue-Based Product Intervertebral Disc Unilateral Or Bilateral Injection With Ct Guidance Lumbar; First 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).	_	_	_
0630T	Percutaneous Injection Of Allogeneic Cellular And/Or Tissue-Based Product Intervertebral Disc Unilateral Or Bilateral Injection With Ct Guidance Lumbar; Each Additional Level (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0631T	Transcutaneous Visible Light Hyperspectral Imaging Measurement Of Oxyhemoglobin Deoxyhemoglobin And Tissue Oxygenation With Interpretation And Report Per Extremity	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0639T	Wireless Skin Sensor Thermal Anisotropy Measurement(S) And Assessment Of Flow In Cerebrospinal Fluid Shunt Including Ultrasound Guidance When Performed	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0640T	Noncontact Near-Infrared Spectroscopy (Eg For Measurement Of Deoxyhemoglobin Oxyhemoglobin And Ratio Of Tissue Oxygenation) Other Than For Screening For Peripheral Arterial Disease Image Acquisition Interpretation And Report; First Anatomic Site	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0643T	Transcatheter Left Ventricular Restoration Device Implantation Including Right And Left Heart Catheterization And Left Ventriculography When Performed Arterial Approach	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0645T	Transcatheter Implantation Of Coronary Sinus Reduction Device Including Vascular Access And Closure Right Heart Catheterization Venous Angiography Coronary Sinus Angiography Imaging Guidance And Supervision And Interpretation When Performed	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

0646T	Transcatheter Tricuspid Valve Implantation (Ttvi)/Replacement With Prosthetic Valve Percutaneous Approach Including Right Heart Catheterization Temporary Pacemaker Insertion And Selective Right Ventricular Or Right Atrial Angiography When Performed	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0650T	Programming Device Evaluation (Remote) Of Subcutaneous Cardiac Rhythm Monitor System With Iterative Adjustment Of The Implantable Device To Test The Function Of The Device And Select Optimal Permanently Programmed Values With Analysis Review And Report By A Physician Or Other Qualified Health Care Professional	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0651T	Magnetically Controlled Capsule Endoscopy Esophagus Through Stomach Including Intraprocedural Positioning Of Capsule With Interpretation And Report	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0656T	Anterior Lumbar Or Thoracolumbar Vertebral Body Tethering; Up To 7 Vertebral Segments	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0657T	Anterior Lumbar Or Thoracolumbar Vertebral Body Tethering; 8 Or More Vertebral Segments	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0658T	Electrical Impedance Spectroscopy Of 1 Or More Skin Lesions For Automated Melanoma Risk Score	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0664T	Donor Hysterectomy (Including Cold Preservation); Open From Cadaver Donor	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0665T	Donor Hysterectomy (Including Cold Preservation); Open From Living Donor	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0666T	Donor Hysterectomy (Including Cold Preservation); Laparoscopic Or Robotic From Living Donor	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0667T	Donor Hysterectomy (Including Cold Preservation); Recipient Uterus Allograft Transplantation From Cadaver Or Living Donor	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_

0668T	Backbench Standard Preparation Of Cadaver Or Living Donor Uterine Allograft Prior To Transplantation Including Dissection And Removal Of Surrounding Soft Tissues And Preparation Of Uterine Vein(S) And Uterine Artery(Ies) As Necessary	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0669T	Backbench Reconstruction Of Cadaver Or Living Donor Uterus Allograft Prior To Transplantation; Venous Anastomosis 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).	_	_	_
0670T	Backbench Reconstruction Of Cadaver Or Living Donor Uterus Allograft Prior To Transplantation; Arterial Anastomosis 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).	_	_	_
0672T	Endovaginal Cryogen-Cooled Monopolar Radiofrequency Remodeling Of The Tissues Surrounding The Female Bladder Neck And Proximal Urethra For Urinary Incontinence	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0692T	Therapeutic Ultrafiltration	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	5/1/2024	_	Add effective 5/1/2024
0714T	Transperineal Laser Ablation Of Benign Prostatic Hyperplasia Including Imaging Guidance	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0716T	Cardiac Acoustic Waveform Recording With Automated Analysis And Generation Of Coronary Artery Disease Risk Score	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0717T	Autologous Adipose-Derived Regenerative Cell (Adrc) Therapy For Partial Thickness Rotator Cuff Tear; Adipose Tissue Harvesting Isolation And Preparation Of Harvested Cells Including Incubation With Cell Dissociation Enzymes Filtration Washing And Concentration Of Adrcs	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0718T	Autologous Adipose-Derived Regenerative Cell (Adrc) Therapy For Partial Thickness Rotator Cuff Tear; Injection Into Supraspinatus Tendon Including Ultrasound Guidance Unilateral	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0719T	Posterior Vertebral Joint Replacement Including Bilateral Facetectomy Laminectomy And Radical Discectomy Including Imaging Guidance Lumbar Spine Single Segment	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

0720T	Percutaneous Electrical Nerve Field Stimulation Cranial Nerves Without Implantation	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0721T	Quantitative Computed Tomography (Ct) Tissue Characterization Including Interpretation And Report Obtained Without Concurrent Ct Examination Of Any Structure Contained In Previously Acquired Diagnostic Imaging	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0722T	Quantitative Computed Tomography (Ct) Tissue Characterization Including Interpretation And Report Obtained With Concurrent Ct Examination Of Any Structure Contained In The Concurrently Acquired Diagnostic Imaging Dataset (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0723T	Quantitative Magnetic Resonance Cholangiopancreatography (Qmrcp) Including Data Preparation And Transmission Interpretation And Report Obtained Without Diagnostic Magnetic Resonance Imaging (Mri) Examination Of The Same Anatomy (Eg Organ Gland Tissue Target Structure) During The Same Session	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0724T	Quantitative Magnetic Resonance Cholangiopancreatography (Qmrcp) Including Data Preparation And Transmission Interpretation And Report Obtained With Diagnostic Magnetic Resonance Imaging (Mri) Examination Of The Same Anatomy (Eg Organ Gland Tissue Target Structure) (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0725T	Vestibular Device Implantation Unilateral	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0726T	Removal Of Implanted Vestibular Device Unilateral	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0727T	Removal And Replacement Of Implanted Vestibular Device Unilateral	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

0728T	Diagnostic Analysis Of Vestibular Implant Unilateral; With Initial Programming	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0729T	Diagnostic Analysis Of Vestibular Implant Unilateral; With Subsequent Programming	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0730T	Trabeculotomy By Laser Including Optical Coherence Tomography (Oct) Guidance	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0731T	Augmentative Ai-Based Facial Phenotype Analysis With Report	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0732T	Immunotherapy Administration With Electroporation Intramuscular	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0733T	Remote Real-Time Motion Capture-Based Neurorehabilitative Therapy Ordered By A Physician Or Other Qualified Health Care Professional; Supply And Technical Support Per 30 Days	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0734T	Remote Real-Time Motion Capture-Based Neurorehabilitative Therapy Ordered By A Physician Or Other Qualified Health Care Professional; Treatment Management Services By A Physician Or Other Qualified Health Care Professional Per Calendar Month	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0735T	Preparation Of Tumor Cavity With Placement Of A Radiation Therapy Applicator For Intraoperative Radiation Therapy (Iort) Concurrent With Primary Craniotomy (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0737T	Xenograft Implantation Into The Articular Surface	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

0740T	Remote Autonomous Algorithm-Based Recommendation System For Insulin Dose Calculation And Titration; Initial Set-Up And Patient Education	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0741T	Remote Autonomous Algorithm-Based Recommendation System For Insulin Dose Calculation And Titration; Provision Of Software Data Collection Transmission And Storage Each 30 Days	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
0743T	Bone Strength And Fracture Risk Using Finite Element Analysis Of Functional Data And Bone Mineral Density (Bmd) With Concurrent Vertebral Fracture Assessment Utilizing Data From A Computed Tomography Scan Retrieval And Transmission Of The Scan Data Measurement Of Bone Strength And Bmd And Classification Of Any Vertebral Fractures With Overall Fracture-Risk Assessment Interpretation And Report	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0744T	Insertion Of Bioprosthetic Valve Open Femoral Vein Including Duplex Ultrasound Imaging Guidance When Performed Including Autogenous Or Nonautogenous Patch Graft (Eg Polyester Eptfe Bovine Pericardium) When Performed	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0745T	Cardiac Focal Ablation Utilizing Radiation Therapy For Arrhythmia; Noninvasive Arrhythmia Localization And Mapping Of Arrhythmia Site (Nidus) Derived From Anatomical Image Data (Eg Ct Mri Or Myocardial Perfusion Scan) And Electrical Data (Eg 12-Lead Ecg Data) And Identification Of Areas Of Avoidance	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0746T	Cardiac Focal Ablation Utilizing Radiation Therapy For Arrhythmia; Conversion Of Arrhythmia Localization And Mapping Of Arrhythmia Site (Nidus) Into A Multidimensional Radiation Treatment Plan	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0747T	Cardiac Focal Ablation Utilizing Radiation Therapy For Arrhythmia; Delivery Of Radiation Therapy Arrhythmia	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0748T	Injections Of Stem Cell Product Into Perianal Perifistular Soft Tissue Including Fistula Preparation (Eg Removal Of Setons Fistula Curettage Closure Of Internal Openings)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0764T	Assistive Algorithmic Electrocardiogram Risk-Based Assessment For Cardiac Dysfunction (Eg Low-Ejection Fraction Pulmonary Hypertension Hypertrophic Cardiomyopathy); Related To Concurrently Performed Electrocardiogram (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

0765T	Assistive Algorithmic Electrocardiogram Risk-Based Assessment For Cardiac Dysfunction (Eg Low-Ejection Fraction Pulmonary Hypertension Hypertrophic Cardiomyopathy); Related To Previously Performed Electrocardiogram	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0766T	Transcutaneous Magnetic Stimulation By Focused Low-Frequency Electromagnetic Pulse Peripheral Nerve With Identification And Marking Of The Treatment Location Including Noninvasive Electroneurographic Localization (Nerve Conduction Localization) When Performed; First 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).	_	_	_
0767T	Transcutaneous Magnetic Stimulation By Focused Low-Frequency Electromagnetic Pulse Peripheral Nerve With Identification And Marking Of The Treatment Location Including Noninvasive Electroneurographic Localization (Nerve Conduction Localization) When Performed; Each Additional Nerve (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0770T	Virtual Reality Technology To Assist Therapy (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0771T	Virtual Reality (Vr) Procedural Dissociation Services Provided By The Same Physician Or Other Qualified Health Care Professional Performing The Diagnostic Or Therapeutic Service That The Vr Procedural Dissociation Supports Requiring The Presence Of An Independent Trained Observer To Assist In The Monitoring Of The Patient'S Level Of Dissociation Or Consciousness And Physiological Status; Initial 15 Minutes Of Intraservice Time Patient Age 5 Years Or Older	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0772T	Virtual Reality (Vr) Procedural Dissociation Services Provided By The Same Physician Or Other Qualified Health Care Professional Performing The Diagnostic Or Therapeutic Service That The Vr Procedural Dissociation Supports Requiring The Presence Of An Independent Trained Observer To Assist In The Monitoring Of The Patient'S Level Of Dissociation Or Consciousness And Physiological Status; Each Additional 15 Minutes Intraservice Time (List Separately In Addition To Code For Primary Service)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_

0773T	Virtual Reality (Vr) Procedural Dissociation Services Provided By A Physician Or Other Qualified Health Care Professional Other Than The Physician Or Other Qualified Health Care Professional Performing The Diagnostic Or Therapeutic Service That The Vr Procedural Dissociation Supports; Initial 15 Minutes Of Intraservice Time Patient Age 5 Years Or Older	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0774T	Virtual Reality (Vr) Procedural Dissociation Services Provided By A Physician Or Other Qualified Health Care Professional Other Than The Physician Or Other Qualified Health Care Professional Performing The Diagnostic Or Therapeutic Service That The Vr Procedural Dissociation Supports; Each Additional 15 Minutes Intraservice Time (List Separately In Addition To Code For Primary Service)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0776T	Therapeutic Induction Of Intra-Brain Hypothermia Including Placement Of A Mechanical Temperature-Controlled Cooling Device To The Neck Over Carotids And Head Including Monitoring (Eg Vital Signs And Sport Concussion Assessment Tool 5 [Scat5]) 30 Minutes Of 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).	_	_	_
0777T	Real-Time Pressure-Sensing Epidural Guidance System (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0778T	Surface Mechanomyography (Smmg) With Concurrent Application Of Inertial Measurement Unit (Imu) Sensors For Measurement Of Multi-Joint Range Of Motion Posture Gait And Muscle Function	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0779T	Gastrointestinal Myoelectrical Activity Study Stomach Through Colon With Interpretation And Report	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0780T	Instillation Of Fecal Microbiota Suspension Via Rectal Enema Into Lower Gastrointestinal Tract	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0781T	Bronchoscopy Rigid Or Flexible With Insertion Of Esophageal Protection Device And Circumferential Radiofrequency Destruction Of The Pulmonary Nerves Including Fluoroscopic Guidance When Performed; Bilateral Mainstem Bronchi	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0782T	Bronchoscopy Rigid Or Flexible With Insertion Of Esophageal Protection Device And Circumferential Radiofrequency Destruction Of The Pulmonary Nerves Including Fluoroscopic Guidance When Performed; Unilateral Mainstem Bronchus	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_

0783T	Transcutaneous Auricular Neurostimulation Set-Up Calibration And Patient Education On Use Of Equipment	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0784T	Insertion Or Replacement Of Percutaneous Electrode Array Spinal With Integrated Neurostimulator Including Imaging Guidance When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
0785T	Revision Or Removal Of Neurostimulator Electrode Array Spinal With Integrated Neurostimulator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
0786T	Insertion Or Replacement Of Percutaneous Electrode Array Sacral With Integrated Neurostimulator Including Imaging Guidance When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
0787T	Revision Or Removal Of Neurostimulator Electrode Array Sacral With Integrated Neurostimulator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
0788T	Electronic Analysis With Simple Programming Of Implanted Integrated Neurostimulation System (Eg Electrode Array And Receiver) Including Contact Group(S) Amplitude Pulse Width Frequency (Hz) On/Off Cycling Burst Dose Lockout Patient-Selectable Parameters Responsive Neurostimulation Detection Algorithms Closed-Loop Parameters And Passive Parameters When Performed By Physician Or Other Qualified Health Care Professional Spinal Cord Or Sacral Nerve 1-3 Parameters	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
0789T	Electronic Analysis With Complex Programming Of Implanted Integrated Neurostimulation System (Eg Electrode Array And Receiver) Including Contact Group(S) Amplitude Pulse Width Frequency (Hz) On/Off Cycling Burst Dose Lockout Patient-Selectable Parameters Responsive Neurostimulation Detection Algorithms Closed-Loop Parameters And Passive Parameters When Performed By Physician Or Other Qualified Health Care Professional Spinal Cord Or Sacral Nerve 4 Or More Parameters	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
0790T	Revision (Eg Augmentation Division Of Tether) Replacement Or Removal Of Thoracolumbar Or Lumbar Vertebral Body Tethering Including Thoracoscopy When Performed	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	5/14/2024	Retire effective 05/14/2024
0790T	Revision (Eg Augmentation Division Of Tether) Replacement Or Removal Of Thoracolumbar Or Lumbar Vertebral Body Tethering Including Thoracoscopy When Performed	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024
0791T	Motor-Cognitive Semi-Immersive Virtual Reality-Facilitated Gait Training Each 15 Minutes (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_

0792T	Application Of Silver Diamine Fluoride 38% By A Physician Or Other Qualified Health Care Professional	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
0793T	Percutaneous Transcatheter Thermal Ablation Of Nerves Innervating The Pulmonary Arteries Including Right Heart Catheterization Pulmonary Artery Angiography And All Imaging Guidance	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0794T	Patient-Specific Assistive Rules-Based Algorithm For Ranking Pharmaco-Oncologic Treatment Options Based On The Patient'S Tumor-Specific Cancer Marker Information Obtained From Prior Molecular Pathology Immunohistochemical Or Other Pathology Results Which Have Been Previously Interpreted And Reported Separately	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0795T	Transcatheter Insertion Of Permanent Dual-Chamber Leadless Pacemaker Including Imaging Guidance (Eg Fluoroscopy Venous Ultrasound Right Atrial Angiography Right Ventriculography Femoral Venography) And Device Evaluation (Eg Interrogation Or Programming) When Performed; Complete System (Ie Right Atrial And Right Ventricular Pacemaker Components)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0796T	Transcatheter Insertion Of Permanent Dual-Chamber Leadless Pacemaker Including Imaging Guidance (Eg Fluoroscopy Venous Ultrasound Right Atrial Angiography Right Ventriculography Femoral Venography) And Device Evaluation (Eg Interrogation Or Programming) When Performed; Right Atrial Pacemaker Component (When An Existing Right Ventricular Single Leadless Pacemaker Exists To Create A Dual-Chamber Leadless Pacemaker System)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0797T	Transcatheter Insertion Of Permanent Dual-Chamber Leadless Pacemaker Including Imaging Guidance (Eg Fluoroscopy Venous Ultrasound Right Atrial Angiography Right Ventriculography Femoral Venography) And Device Evaluation (Eg Interrogation Or Programming) When Performed; Right Ventricular Pacemaker Component (When Part Of A Dual-Chamber Leadless Pacemaker System)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0798T	Transcatheter Removal Of Permanent Dual-Chamber Leadless Pacemaker Including Imaging Guidance (Eg Fluoroscopy Venous Ultrasound Right Atrial Angiography Right Ventriculography Femoral Venography) When Performed; Complete System (Ie Right Atrial And Right Ventricular Pacemaker Components)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

0799T	Transcatheter Removal Of Permanent Dual-Chamber Leadless Pacemaker Including Imaging Guidance (Eg Fluoroscopy Venous Ultrasound Right Atrial Angiography Right Ventriculography Femoral Venography) When Performed; Right Atrial Pacemaker Component	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0800T	Transcatheter Removal Of Permanent Dual-Chamber Leadless Pacemaker Including Imaging Guidance (Eg Fluoroscopy Venous Ultrasound Right Atrial Angiography Right Ventriculography Femoral Venography) When Performed; Right Ventricular Pacemaker Component (When Part Of A Dual-Chamber Leadless Pacemaker System)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0801T	Transcatheter Removal And Replacement Of Permanent Dual-Chamber Leadless Pacemaker Including Imaging Guidance (Eg Fluoroscopy Venous Ultrasound Right Atrial Angiography Right Ventriculography Femoral Venography) And Device Evaluation (Eg Interrogation Or Programming) When Performed; Dual-Chamber System (Ie Right Atrial And Right Ventricular Pacemaker Components)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0802T	Transcatheter Removal And Replacement Of Permanent Dual-Chamber Leadless Pacemaker Including Imaging Guidance (Eg Fluoroscopy Venous Ultrasound Right Atrial Angiography Right Ventriculography Femoral Venography) And Device Evaluation (Eg Interrogation Or Programming) When Performed; Right Atrial Pacemaker Component	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0803T	Transcatheter Removal And Replacement Of Permanent Dual-Chamber Leadless Pacemaker Including Imaging Guidance (Eg Fluoroscopy Venous Ultrasound Right Atrial Angiography Right Ventriculography Femoral Venography) And Device Evaluation (Eg Interrogation Or Programming) When Performed; Right Ventricular Pacemaker Component (When Part Of A Dual-Chamber Leadless Pacemaker System)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0804T	Programming Device Evaluation (In Person) With Iterative Adjustment Of Implantable Device To Test The Function Of Device And To Select Optimal Permanent Programmed Values With Analysis Review And Report By A Physician Or Other Qualified Health Care Professional Leadless Pacemaker System In Dual Cardiac Chambers	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0805T	Transcatheter Superior And Inferior Vena Cava Prosthetic Valve Implantation (Ie Caval Valve Implantation [Cavi]); Percutaneous Femoral Vein Approach	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

0806T	Transcatheter Superior And Inferior Vena Cava Prosthetic Valve Implantation (Ie Caval Valve Implantation [Cavi]); Open Femoral Vein Approach	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0807T	Pulmonary Tissue Ventilation Analysis Using Software-Based Processing Of Data From Separately Captured Cinefluorograph Images; In Combination With Previously Acquired Computed Tomography (Ct) Images Including Data Preparation And Transmission Quantification Of Pulmonary Tissue Ventilation Data Review Interpretation And Report	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0808T	Pulmonary Tissue Ventilation Analysis Using Software-Based Processing Of Data From Separately Captured Cinefluorograph Images; In Combination With Computed Tomography (Ct) Images Taken For The Purpose Of Pulmonary Tissue Ventilation Analysis Including Data Preparation And Transmission Quantification Of Pulmonary Tissue Ventilation Data Review Interpretation And Report	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
0810T	Subretinal Injection Of A Pharmacologic Agent Including Vitrectomy And 1 Or More Retinotomies	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
0811T	Remote Multi-Day Complex Uroflowmetry (Eg Calibrated Electronic Equipment); Set-Up And Patient Education On Use Of Equipment	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
0812T	Remote Multi-Day Complex Uroflowmetry (Eg Calibrated Electronic Equipment); Device Supply With Automated Report Generation Up To 10 Days	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
0813T	Esophagogastroduodenoscopy Flexible Transoral With Volume Adjustment Of Intragastric Bariatric Balloon	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	6/30/2024	Add effective 01/01/2024 Retire effective 06/30/2024
0813T	Esophagogastroduodenoscopy Flexible Transoral With Volume Adjustment Of Intragastric Bariatric Balloon	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
0814T	Percutaneous Injection Of Calcium-Based Biodegradable Osteoconductive Material Proximal Femur Including Imaging Guidance Unilateral	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
0816T	Open Insertion Or Replacement Of Integrated Neurostimulation System For Bladder Dysfunction Including Electrode(S) (Eg Array Or Leadless) And Pulse Generator Or Receiver Including Analysis Programming And Imaging Guidance When Performed Posterior Tibial Nerve; Subcutaneous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	6/30/2024	Add effective 01/01/2024 Retire effective 06/30/2024

0816T	Open Insertion Or Replacement Of Integrated Neurostimulation System For Bladder Dysfunction Including Electrode(S) (Eg Array Or Leadless) And Pulse Generator Or Receiver Including Analysis Programming And Imaging Guidance When Performed Posterior Tibial Nerve; Subcutaneous	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
0817T	Open Insertion Or Replacement Of Integrated Neurostimulation System For Bladder Dysfunction Including Electrode(S) (Eg Array Or Leadless) And Pulse Generator Or Receiver Including Analysis Programming And Imaging Guidance When Performed Posterior Tibial Nerve; Subfascial	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
0818T	Revision Or Removal Of Integrated Neurostimulation System For Bladder Dysfunction Including Analysis Programming And Imaging When Performed Posterior Tibial Nerve; Subcutaneous	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	6/30/2024	Add effective 01/01/2024 Retire effective 06/30/2024
0818T	Revision Or Removal Of Integrated Neurostimulation System For Bladder Dysfunction Including Analysis Programming And Imaging When Performed Posterior Tibial Nerve; Subcutaneous	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
0819T	Revision Or Removal Of Integrated Neurostimulation System For Bladder Dysfunction Including Analysis Programming And Imaging When Performed Posterior Tibial Nerve; Subfascial	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
0820T	Continuous In-Person Monitoring And Intervention (Eg Psychotherapy Crisis Intervention) As Needed During Psychedelic Medication Therapy; First Physician Or Other Qualified Health Care Professional Each Hour	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
0821T	Continuous In-Person Monitoring And Intervention (Eg Psychotherapy Crisis Intervention) As Needed During Psychedelic Medication Therapy; Second Physician Or Other Qualified Health Care Professional Concurrent With First Physician Or Other Qualified Health Care Professional Each Hour (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
0822T	Continuous In-Person Monitoring And Intervention (Eg Psychotherapy Crisis Intervention) As Needed During Psychedelic Medication Therapy; Clinical Staff Under The Direction Of A Physician Or Other Qualified Health Care Professional Concurrent With First Physician Or Other Qualified Health Care Professional Each Hour (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
0857T	Opto-Acoustic Imaging Breast Unilateral Including Axilla When Performed Real-Time With Image Documentation Augmentative Analysis And Report (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024

0858T	Externally Applied Transcranial Magnetic Stimulation With Concomitant Measurement Of Evoked Cortical Potentials With Automated Report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
0861T	Removal Of Pulse Generator For Wireless Cardiac Stimulator For Left Ventricular Pacing; Both Components (Battery And Transmitter)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
0862T	Relocation Of Pulse Generator For Wireless Cardiac Stimulator For Left Ventricular Pacing Including Device Interrogation And Programming; Battery Component Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
0863T	Relocation Of Pulse Generator For Wireless Cardiac Stimulator For Left Ventricular Pacing Including Device Interrogation And Programming; Transmitter Component Only	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
0864T	Low-Intensity Extracorporeal Shock Wave Therapy Involving Corpus Cavernosum Low Energy	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	6/30/2024	Add effective 01/01/2024 Retire effective 06/30/2024
0864T	Low-Intensity Extracorporeal Shock Wave Therapy Involving Corpus Cavernosum Low Energy	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
0865T	Quantitative Magnetic Resonance Image (Mri) Analysis Of The Brain With Comparison To Prior Magnetic Resonance (Mr) Study(Ies) Including Lesion Identification Characterization And Quantification With Brain Volume(S) Quantification And/Or Severity Score When Performed Data Preparation And Transmission Interpretation And Report Obtained Without Diagnostic Mri Examination Of The Brain During The Same Session	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
0866T	Quantitative Magnetic Resonance Image (Mri) Analysis Of The Brain With Comparison To Prior Magnetic Resonance (Mr) Study(Ies) Including Lesion Detection Characterization And Quantification With Brain Volume(S) Quantification And/Or Severity Score When Performed Data Preparation And Transmission Interpretation And Report Obtained With Diagnostic Mri Examination Of The Brain (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
9701A	Non-Prescription Drugs	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
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	Non-Emergency Transportation: Ancillary: Meals-Recipient	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
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)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A0427	Ambulance Service Advanced Life Support Emergency Transport Level 1 (Als1-Emergency)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A0428	Ambulance Service Basic Life Support Non-Emergency Transport (Bls)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A0430	Ambulance Service Conventional Air Services Transport One Way (Fixed Wing)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

A0431	Ambulance Service Conventional Air Services Transport One Way (Rotary Wing)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A0432	Paramedic Intercept (Pi) Rural Area Transport Furnished By A Volunteer Ambulance Company Which Is Prohibited By State Law From Billing Third Party Payers	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
A0435	Fixed Wing Air Mileage Per Statute Mile	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A0436	Rotary Wing Air Mileage Per Statute Mile	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A0888	Noncovered Ambulance Mileage 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	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A0999	Unlisted Ambulance Service	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
A2001	Innovamatrix Ac Per 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).	_	_	_
A2002	Mirragen Advanced 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).	_	_	_
A2004	Xcellistem 1 Mg	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
A2005	Microlyte Matrix Per 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).	_	_	_

A2006	Novosorb Synpath Dermal 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).	_	_	_
A2007	Restrata 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).	_	_	_
A2008	Theragenesis 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).	_	_	_
A2009	Symphony 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).	_	_	_
A2010	Apis Per Square Centimeter	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
A2011	Supra Sdrm Per 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).	_	_	_
A2012	Suprathel 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).	_	_	_
A2013	Innovamatrix Fs 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).	_	_	_
A2014	Omeza Collagen Matrix Per 100 Mg	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
A2015	Phoenix 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).	_	_	_
A2016	Permeaderm B 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).	_	_	_

A2017	Permeaderm Glove Each	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
A2018	Permeaderm C 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).	_	_	_
A2019	Kerecis Omega3 Marigen Shield 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).	_	_	_
A2020	Ac5 Advanced Wound System (Ac5)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
A2021	Neomatrix 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).	_	_	_
A2022	Innovaburn Or Innovamatrix Xl 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).	_	_	_
A2023	Innovamatrix Pd 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).	_	_	_
A2024	Resolve 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).	_	_	_
A2025	Miro3D Per Cubic 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).	_	_	_
A2026	Restrata Minimatrix 5 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2024	_	Add effective 04/01/2024
A4100	Skin Substitute Fda Cleared As A Device Not Otherwise Specified	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

A4238	Supply Allowance For Adjunctive Non-Implanted Continuous Glucose Monitor (Cgm) Includes All Supplies And Accessories 1 Month Supply = 1 Unit Of Service	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A4335	Incontinence Supply; Miscellaneous	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
A4341	Indwelling Intraurethral Drainage Device With Valve Patient Inserted Replacement Only Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
A4342	Accessories For Patient Inserted Indwelling Intraurethral Drainage Device With Valve Replacement Only Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service 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.	_	_	_
A4438	Adhesive Clip Applied To The Skin To Secure External Electrical Nerve Stimulator Controller Each	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2024	_	Add effective 4/1/2024
A4453	Rectal Catheter For Use With The Manual Pump-Operated Enema System Replacement Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A4457	Enema Tube With Or Without Adapter Any Type Replacement Only Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
A4458	Enema Bag With Tubing Reusable	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
A4468	Exsufflation Belt Includes All Supplies And Accessories	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
A4520	Incontinence Garment Any Type (E.G. Brief Diaper) Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
A4540	Distal Transcutaneous Electrical Nerve Stimulator Stimulates Peripheral Nerves Of The Upper Arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	5/14/2024	Retire effective 05/14/2024
A4540	Distal Transcutaneous Electrical Nerve Stimulator Stimulates Peripheral Nerves Of The Upper Arm	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024
A4541	Monthly Supplies For Use Of Device Coded At E0733	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
A4542	Supplies And Accessories For External Upper Limb Tremor Stimulator Of The Peripheral Nerves Of The Wrist	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	5/14/2024	Retire effective 05/14/2024

A4542	Supplies And Accessories For External Upper Limb Tremor Stimulator Of The Peripheral Nerves Of The Wrist	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024
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	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A4560	Neuromuscular Electrical Stimulator (Nmes) Disposable Replacement Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	1/14/2024	Retire effective 1/14/2024
A4560	Neuromuscular Electrical Stimulator (Nmes) Disposable Replacement Only	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	1/15/2024	_	Add effective 01/15/2024
A4575	Topical Hyperbaric Oxygen Chamber Disposable	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
A4595	Electrical Stimulator Supplies 2 Lead Per Month (E. G. Tens Nmes)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
A4596	Cranial Electrotherapy Stimulation (Ces) System Supplies And Accessories Per Month	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
A4600	Sleeve For Intermittent Limb Compression Device Replacement Only Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A4630	Replacement Batteries Medically Necessary Transcutaneous Electrical Stimulator Owned By Patient	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
A4638	Replacement Battery For Patient-Owned Ear Pulse Generator Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A4639	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).	_	_	_

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).	_	_	_
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 Garment 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	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A6590	External Urinary Catheters; Disposable With Wicking Material For Use With Suction Pump Per Month	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
A6591	External Urinary Catheter; Non-Disposable For Use With Suction Pump Per Month	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_

A7020	Interface For Cough Stimulating Device Includes All Components Replacement Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A7025	High Frequency Chest Wall Oscillation System Vest Replacement For Use With Patient Owned Equipment Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A7026	High Frequency Chest Wall Oscillation System Hose Replacement For Use With Patient Owned Equipment Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A7047	Oral Interface Used With Respiratory Suction Pump Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A7049	Expiratory Positive Airway Pressure Intranasal Resistance Valve	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
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 the Plan. Not subject to utilization review. Unlisted or Undefined	_	_	_
A9153	Multiple Vitamins With Or Without Minerals And Trace Elements Oral Per Dose Not Otherwise Specified	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review. Unlisted or Undefined	_	_	_
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	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A9273	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.	_	_	_
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).	_	_	_
A9291	Prescription Digital Cognitive And/Or Behavioral Therapy Fda Cleared Per Course Of 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).	_	1/31/2024	Retire effective 1/31/2024
A9291	Prescription Digital Cognitive And/Or Behavioral Therapy Fda Cleared Per Course Of Treatment	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	2/1/2024	_	Add effective 02/01/2024
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	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A9579	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	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A9582	Iodine I-123 Iobenguane Diagnostic Per Study Dose Up To 15 Millicuries	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A9588	Fluciclovine F-18 Diagnostic 1 Millicurie	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A9596	Gallium Ga-68 Gozetotide Diagnostic (Illuccix) 1 Millicurie	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

A9597	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 F 18 Injection Diagnostic 1 Millicurie	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
A9602	Fluorodopa F-18 Diagnostic Per Millicurie	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
A9608	Flotufolastat F 18 Diagnostic 1 Millicurie	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
A9609	Fludeoxyglucose F18 Up To 15 Millicuries	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
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 Ga-68 Gozetotide Diagnostic (Locametz) 1 Millicurie	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
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	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
B4149	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	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
B4154	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	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
B4155	Enteral Formula Nutritionally Incomplete/Modular Nutrients Includes Specific Nutrients Carbohydrates (E. G. Glucose Polymers) Proteins/Amino Acids (E. G. Glutamine Arginine) Fat (E. G. Medium Chain Triglycerides) Or Combination Administered Through An Enteral Feeding Tube 100 Calories = 1 Unit	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
B4157	Enteral Formula Nutritionally Complete For Special Metabolic Needs For Inherited Disease Of Metabolism Includes Proteins Fats Carbohydrates Vitamins And Minerals May Include Fiber Administered Through An Enteral Feeding Tube 100 Calories = 1 Unit	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
B4158	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	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

B4159	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	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
B4160	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	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
B4161	Enteral Formula For Pediatrics Hydrolyzed/Amino Acids And Peptide Chain Proteins Includes Fats Carbohydrates Vitamins And Minerals May Include Fiber Administered Through An Enteral Feeding Tube 100 Calories = 1 Unit	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
B4162	Enteral Formula For Pediatrics Special Metabolic Needs For Inherited Disease Of Metabolism Includes Proteins Fats Carbohydrates Vitamins And Minerals May Include Fiber Administered Through An Enteral Feeding Tube 100 Calories = 1 Unit	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
B4164	Parenteral Nutrition Solution: Carbohydrates (Dextrose) 50% Or Less (500 Ml = 1 Unit) - Homemix	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
B4168	Parenteral Nutrition Solution; Amino Acid 3. 5% (500 Ml = 1 Unit) - Homemix	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
B4172	Parenteral Nutrition Solution; Amino Acid 5. 5% Through 7% (500 Ml = 1 Unit) - Homemix	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
B4176	Parenteral Nutrition Solution; Amino Acid 7% Through 8. 5% (500 Ml = 1 Unit) - Homemix	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
B4178	Parenteral Nutrition Solution: Amino Acid Greater Than 8. 5% (500 Ml = 1 Unit) - Homemix	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

B4180	Parenteral Nutrition Solution; Carbohydrates (Dextrose) Greater Than 50% (500 Ml=1 Unit) - Homemix	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
B4185	Parenteral Nutrition Solution Not Otherwise Specified 10 Grams Lipids	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
B4193	Parenteral Nutrition Solution; Compounded Amino Acid And Carbohydrates With Electrolytes Trace Elements And Vitamins Including Preparation Any Strength 52 To 73 Grams Of Protein - Premix	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
B4197	Parenteral Nutrition Solution; Compounded Amino Acid And Carbohydrates With Electrolytes Trace Elements And Vitamins Including Preparation Any Strength 74 To 100 Grams Of Protein - Premix	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
B4199	Parenteral Nutrition Solution; Compounded Amino Acid And Carbohydrates With Electrolytes Trace Elements And Vitamins Including Preparation Any Strength Over 100 Grams Of Protein - Premix	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
B4216	Parenteral Nutrition; Additives (Vitamins Trace Elements Heparin Electrolytes) Homemix Per Day	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
B4220	Parenteral Nutrition Supply Kit; Premix Per Day	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
B4222	Parenteral Nutrition Supply Kit; Home Mix Per Day	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
B4224	Parenteral Nutrition Administration Kit Per Day	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

B5000	Parenteral Nutrition Solution Compounded Amino Acid And Carbohydrates With Electrolytes Trace Elements And Vitamins Including Preparation Any Strength Renal-Aminosyn-Rf Nephramine Renamine-Premix	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
B5100	Parenteral Nutrition Solution Compounded Amino Acid And Carbohydrates With Electrolytes Trace Elements And Vitamins Including Preparation Any Strength Hepatic Hepatamine-Premix	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
B5200	Parenteral Nutrition Solution Compounded Amino Acid And Carbohydrates With Electrolytes Trace Elements And Vitamins Including Preparation Any Strength Stress-Branch Chain Amino Acids-Freamine-Hbc-Premix	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
B9004	Parenteral Nutrition Infusion Pump Portable	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
B9006	Parenteral Nutrition Infusion Pump Stationary	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
B9998	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 Gastrointestinal Topical	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
C1062	Intravertebral Body Fracture Augmentation With Implant (E.G. Metal Polymer)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
C1600	Catheter Transluminal Intravascular Lesion Preparation Device Bladed Sheathed (Insertable)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024

C1726	Cath Bal Dil Non-Vascular	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
C1761	Catheter Transluminal Intravascular Lithotripsy Coronary	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
C1764	Event Recorder Cardiac	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
C1767	Generator Neurostimulator (Implantable) Non-Rechargeable	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
C1776	Joint Device (Implantable)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
C1778	Lead Neurostimulator	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
C1783	Ocular Implant Aqueous Drainage Assist Device	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
C1787	Patient Progr Neurostim	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
C1816	Receiver/Transmitter Neuro	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

C1817	Septal Defect Imp Sys	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
C1818	Integrated Keratoprosthesis	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
C1820	Generator Neurostimulator (Implantable) With Rechargeable Battery And Charging System	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
C1821	Interspinous Process Distraction Device (Implantable)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
C1822	Generator Neurostimulator (Implantable) High Frequency With Rechargeable Battery And Charging System	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
C1823	Generator Neurostimulator (Implantable) Non-Rechargeable With Transvenous Sensing And Stimulation Leads	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
C1824	Generator Cardiac Contractility Modulation (Implantable)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	3/15/2024	_	Add effectuce 03/15/2024
C1825	Generator Neurostimulator (Implantable) Non-Rechargeable With Carotid Sinus Baroreceptor Stimulation Lead(S)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
C1826	Generator Neurostimulator (Implantable) Includes Closed Feedback Loop Leads And All Implantable Components With Rechargeable Battery And Charging System	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
C1827	Generator Neurostimulator (Implantable) Non-Rechargeable With Implantable Stimulation Lead And External Paired Stimulation Controller	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_

C1831	Interbody Cage Anterior Lateral Or Posterior Personalized (Implantable)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
C1832	Autograft Suspension Including Cell Processing And Application And All System Components	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	5/14/2024	Retire effective 05/14/2024
C1832	Autograft Suspension Including Cell Processing And Application And All System Components	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024
C1833	Monitor Cardiac Including Intracardiac Lead And All System Components (Implantable)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
C1883	Adapt/Ext Pacing/Neuro Lead	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
C1889	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	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
C2616	Brachytx Source Yttrium-90 "Non-Stranded"	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
C2623	Catheter Transluminal Angioplasty Drug-Coated Non-Laser	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
C2624	Implantable Wireless Pulmonary Artery Pressure Sensor With Delivery Catheter Including All System Components	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

C2698	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.	_	_	_
C5271	Application Of Low Cost Skin Substitute Graft To Trunk Arms Legs Total Wound Surface Area Up To 100 Sq Cm; First 25 Sq Cm Or Less Wound Surface Area	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
C5272	Application Of Low Cost Skin Substitute Graft To Trunk Arms Legs Total Wound Surface Area Up To 100 Sq Cm; Each Additional 25 Sq Cm Wound Surface Area Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
C5273	Application Of Low Cost Skin Substitute Graft To Trunk Arms Legs Total Wound Surface Area Greater Than Or Equal To 100 Sq Cm; First 100 Sq Cm Wound Surface Area Or 1% Of Body Area Of Infants And Children	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
C5274	Application Of Low Cost Skin Substitute Graft To Trunk Arms Legs Total Wound Surface Area Greater Than Or Equal To 100 Sq Cm; Each Additional 100 Sq Cm Wound Surface Area Or Part Thereof Or Each Additional 1% Of Body Area Of Infants And Children Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
C5275	Application Of Low Cost Skin Substitute Graft To Face Scalp Eyelids Mouth Neck Ears Orbits Genitalia Hands Feet And/Or Multiple Digits Total Wound Surface Area Up To 100 Sq Cm; First 25 Sq Cm Or Less Wound Surface Area	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
C5276	Application Of Low Cost Skin Substitute Graft To Face Scalp Eyelids Mouth Neck Ears Orbits Genitalia Hands Feet And/Or Multiple Digits Total Wound Surface Area Up To 100 Sq Cm; Each Additional 25 Sq Cm Wound Surface Area Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
C5277	Application Of Low Cost Skin Substitute Graft To Face Scalp Eyelids Mouth Neck Ears Orbits Genitalia Hands Feet And/Or Multiple Digits Total Wound Surface Area Greater Than Or Equal To 100 Sq Cm; First 100 Sq Cm Wound Surface Area Or 1% Of Body Area Of Infants And Children	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

C5278	Application Of Low Cost Skin Substitute Graft To Face Scalp Eyelids Mouth Neck Ears Orbits Genitalia Hands Feet And/Or Multiple Digits Total Wound Surface Area Greater Than Or Equal To 100 Sq Cm; Each Additional 100 Sq Cm Wound Surface Area Or Part Thereof Or Each Additional 1% Of Body Area Of Infants And Children Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
C9160	Injection, daxibotulinumtoxina-lanm, 1 unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	3/31/2024	Retire effective 03/31/2024
C9161	Injection, aflibercept hd, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	3/31/2024	Retire effective 03/31/2024
C9163	Injection, talquetamab-tgvs, 0.25 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	3/31/2024	Retire effective 03/31/2024
C9165	Injection, elranatamab-bcmm, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	3/31/2024	Retire effective 03/31/2024
C9166	Injection Secukinumab Intravenous 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2024	_	Add effective 4/1/2024
C9168	Injection, mirikizumab-mrkz, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2024	_	Add effective 4/1/2024
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).	_	_	_
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).	_	_	_
C9358	Dermal Substitute Native Non-Denatured Collagen Fetal Bovine Origin (Surgimend Collagen Matrix) Per 0.5 Square Centimeters	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
C9360	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).	_	_	_
C9363	Skin Substitute Integra Meshed Bilayer 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).	_	_	_

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).	_	_	_
C9399	Unclassified Drugs Or Biologicals	Unlisted Procedure; May require Prior Authorization per contract agreement.	_	_	_
C9734	Focused Ultrasound Ablation/Therapeutic Intervention Other Than Uterine Leiomyomata With Magnetic Resonance (Mr) Guidance	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
C9739	Cystourethroscopy With Insertion Of Transprostatic Implant; 1 To 3 Implants	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
C9740	Cystourethroscopy With Insertion Of Transprostatic Implant; 4 Or More Implants	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
C9757	Laminotomy (Hemilaminectomy) With Decompression Of Nerve Root(S) Including Partial Facetectomy Foraminotomy And Excision Of Herniated Intervertebral Disc And Repair Of Annular Defect With Implantation Of Bone Anchored Annular Closure Device Including Annular Defect Measurement Alignment And Sizing Assessment And Image Guidance; 1 Interspace 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).	_	_	_
C9764	Revascularization Endovascular Open Or Percutaneous Any Vessel(S); With Intravascular Lithotripsy Includes Angioplasty Within The Same Vessel(S) When Performed	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
C9765	Revascularization Endovascular Open Or Percutaneous Any Vessel(S); With Intravascular Lithotripsy And Transluminal Stent Placement(S) Includes Angioplasty Within The Same Vessel(S) When Performed	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
C9766	Revascularization Endovascular Open Or Percutaneous Any Vessel(S); With Intravascular Lithotripsy And Atherectomy Includes Angioplasty Within The Same Vessel(S) When Performed	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

C9767	Revascularization Endovascular Open Or Percutaneous Any Vessel(S); With Intravascular Lithotripsy And Transluminal Stent Placement(S) And Atherectomy Includes Angioplasty Within The Same Vessel(S) When Performed	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
C9768	Endoscopic Ultrasound-Guided Direct Measurement Of Hepatic Portosystemic Pressure Gradient By Any Method (List Separately In Addition To Code For Primary Procedure)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
C9769	Cystourethroscopy With Insertion Of Temporary Prostatic Implant/Stent With Fixation/Anchor And Incisional Struts	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
C9772	Revascularization Endovascular Open Or Percutaneous Tibial/Peroneal Artery(Ies) With Intravascular Lithotripsy Includes Angioplasty Within The Same Vessel (S) When Performed	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
C9773	Revascularization Endovascular Open Or Percutaneous Tibial/Peroneal Artery(Ies); With Intravascular Lithotripsy And Transluminal Stent Placement(S) Includes Angioplasty Within The Same Vessel(S) When Performed	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
C9774	Revascularization Endovascular Open Or Percutaneous Tibial/Peroneal Artery(Ies); With Intravascular Lithotripsy And Atherectomy Includes Angioplasty Within The Same Vessel (S) When Performed	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
C9775	Revascularization Endovascular Open Or Percutaneous Tibial/Peroneal Artery(Ies); With Intravascular Lithotripsy And Transluminal Stent Placement(S) And Atherectomy Includes Angioplasty Within The Same Vessel (S) When Performed	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
C9777	Esophageal Mucosal Integrity Testing By Electrical Impedance Transoral Includes Esophagoscopy Or Esophagogastroduodenoscopy	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
C9780	Insertion Of Central Venous Catheter Through Central Venous Occlusion Via Inferior And Superior Approaches (E.G. Inside-Out Technique) Including Imaging Guidance	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

C9782	Blinded Procedure For New York Heart Association (Nyha) Class Ii Or Iii Heart Failure Or Canadian Cardiovascular Society (Ccs) Class Iii Or Iv Chronic Refractory Angina; Transcatheter Intramyocardial Transplantation Of Autologous Bone Marrow Cells (E.G. Mononuclear) Or Placebo Control Autologous Bone Marrow Harvesting And Preparation For Transplantation Left Heart Catheterization Including Ventriculography All Laboratory Services And All Imaging With Or Without Guidance (E.G. Transthoracic Echocardiography Ultrasound Fluoroscopy) Performed In An Approved Investigational Device Exemption (Ide) Study	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	2/1/2024	_	Add effective 02/01/2024
C9784	Gastric Restrictive Procedure Endoscopic Sleeve Gastroplasty With Esophagogastroduodenoscopy And Intraluminal Tube Insertion If Performed Including All System And Tissue Anchoring 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).	_	_	_
C9785	Endoscopic Outlet Reduction Gastric Pouch Application With Endoscopy And Intraluminal Tube Insertion If Performed Including All System And Tissue Anchoring 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).	_	_	_
C9786	Echocardiography Image Post Processing For Computer Aided Detection Of Heart Failure With Preserved Ejection Fraction Including Interpretation And Report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
C9787	Gastric Electrophysiology Mapping With Simultaneous Patient Symptom Profiling	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
C9793	3D Predictive Model Generation For Pre-Planning Of A Cardiac Procedure Using Data From Cardiac Computed Tomographic Angiography With Report	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
C9794	Therapeutic Radiology Simulation-Aided Field Setting; Complex Including Acquisition Of Pet And Ct Imaging Data Required For Radiopharmaceutical-Directed Radiation Therapy Treatment Planning (I.E. Modeling)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
C9795	Stereotactic Body Radiation Therapy Treatment Delivery Per Fraction To 1 Or More Lesions Including Image Guidance And Real-Time Positron Emissions-Based Delivery Adjustments To 1 Or More Lesions Entire Course Not To Exceed 5 Fractions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
C9796	Repair Of Enterocutaneous Fistula Small Intestine Or Colon (Excluding Anorectal Fistula) With Plug (E.G. Porcine Small Intestine Submucosa [Sis])	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2024	6/30/2024	retire effectuce 06/30/2024
C9796	Repair Of Enterocutaneous Fistula Small Intestine Or Colon (Excluding Anorectal Fistula) With Plug (E.G. Porcine Small Intestine Submucosa [Sis])	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024

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.	_	_	_
D0396	3D Printing Of A 3D Dental Surface Scan	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
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.	_	_	_
D1301	Immunization Counseling	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
D1705	Astrazeneca Covid-19 Vaccine Administration – First Dose	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
D1706	Astrazeneca Covid-19 Vaccine Administration – Second Dose	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
D1999	Unspecified Preventive Procedure By Report	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
D2989	Excavation Of A Tooth Resulting In The Determination Of Non-Restorability	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
D2991	Application Of Hydroxyapatite Regeneration Medicament - Per Tooth	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
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.	_	_	_

D7939	Indexing For Osteotomy Using Dynamic Robotic Assisted Or Dynamic Navigation	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
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.	_	_	_
D9938	Fabrication Of A Custom Removable Clear Plastic Temporary Aesthetic Appliance	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
D9939	Placement Of A Custom Removable Clear Plastic Temporary Aesthetic Appliance	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
D9954	Fabrication And Delivery Of Oral Appliance Therapy (Oat) Morning Repositioning Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
D9955	Oral Appliance Therapy (Oat) Titration Visit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
D9956	Administration Of Home Sleep Apnea Test	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
D9957	Screening For Sleep Related Breathing Disorders	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
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.	_	_	_
E0152	Walker Battery Powered Wheeled Folding Adjustable Or Fixed Height	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2024	_	Add effective 4/1/2024
E0181	Powered Pressure Reducing Mattress Overlay/Pad Alternating With Pump Includes Heavy Duty	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0182	Pump For Alternating Pressure Pad For Replacement Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0183	Powered Pressure Reducing Underlay/Pad Alternating With Pump Includes Heavy Duty	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

E0184	Dry Pressure Mattress	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0185	Gel Or Gel-Like Pressure Pad For Mattress Standard Mattress Length And Width	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0186	Air Pressure Mattress	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0187	Water Pressure Mattress	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0190	Positioning Cushion/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)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0194	Air Fluidized Bed	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0196	Gel Pressure Mattress	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0217	Water Circulating Heat Pad With Pump	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0218	Fluid Circulating Cold Pad With Pump Any Type	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

E0221	Infrared Heating Pad System	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
E0225	Hydrocollator Unit Includes Pads	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0231	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).	_	_	_
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).	_	_	_
E0236	Pump For Water Circulating Pad	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0239	Hydrocollator Unit Portable	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0240	Bath/Shower Chair With Or Without Wheels Any Size	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
E0241	Bath Tub Wall Rail Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
E0242	Bath Tub Rail Floor Base	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
E0243	Toilet Rail Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
E0244	Raised Toilet Seat	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
E0245	Tub Stool Or Bench	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
E0246	Transfer Tub Rail Attachment	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
E0247	Transfer Bench For Tub Or Toilet With Or Without Commode Opening	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
E0248	Transfer Bench Heavy Duty For Tub Or Toilet With Or Without Commode Opening	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_

E0249	Pad For Water Circulating Heat Unit For Replacement Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0250	Hospital Bed Fixed Height With Any Type Side Rails With Mattress	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0251	Hospital Bed Fixed Height With Any Type Side Rails Without Mattress	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0255	Hospital Bed Variable Height Hi-Lo With Any Type Side Rails With Mattress	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0256	Hospital Bed Variable Height Hi-Lo With Any Type Side Rails Without Mattress	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0260	Hospital Bed Semi-Electric (Head And Foot Adjustment) With Any Type Side Rails With Mattress	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0261	Hospital Bed Semi-Electric (Head And Foot Adjustment) With Any Type Side Rails Without Mattress	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0265	Hospital Bed Total Electric (Head Foot And Height Adjustments) With Any Type Side Rails With Mattress	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0266	Hospital Bed Total Electric (Head Foot And Height Adjustments) With Any Type Side Rails Without Mattress	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

E0270	Hospital Bed Institutional Type Includes: Oscillating Circulating And Stryker Frame With Mattress	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0271	Mattress Innerspring	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0272	Mattress Foam Rubber	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0273	Bed Board	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0274	Over-Bed Table	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0277	Powered Pressure-Reducing Air Mattress	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0280	Bed Cradle Any Type	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0290	Hospital Bed Fixed Height Without Side Rails With Mattress	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0291	Hospital Bed Fixed Height Without Side Rails Without Mattress	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

E0292	Hospital Bed Variable Height Hi-Lo Without Side Rails With Mattress	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0293	Hospital Bed Variable Height Hi-Lo Without Side Rails Without Mattress	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0294	Hospital Bed Semi-Electric (Head And Foot Adjustment) Without Side Rails With Mattress	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0295	Hospital Bed Semi-Electric (Head And Foot Adjustment) Without Side Rails Without Mattress	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0296	Hospital Bed Total Electric (Head Foot And Height Adjustments). Without Side Rails With Mattress	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0297	Hospital Bed Total Electric (Head Foot And Height Adjustments) Without Side Rails Without Mattress	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0300	Pediatric Crib Hospital Grade Fully Enclosed With Or Without Top Enclosure	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0301	Hospital Bed Heavy Duty Extra Wide With Weight Capacity Greater Than 350 Pounds But Less Than Or Equal To 600 Pounds With Any Type Side Rails Without Mattress	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0302	Hospital Bed Extra Heavy Duty Extra Wide With Weight Capacity Greater Than 600 Pounds With Any Type Side Rails Without Mattress	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

E0303	Hospital Bed Heavy Duty Extra Wide With Weight Capacity Greater Than 350 Pounds But Less Than Or Equal To 600 Pounds With Any Type Side Rails With Mattress	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0304	Hospital Bed Extra Heavy Duty Extra Wide With Weight Capacity Greater Than 600 Pounds With Any Type Side Rails With Mattress	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0305	Bed Side Rails Half Length	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0310	Bed Side Rails Full Length	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0315	Bed Accessory: Board Table Or Support Device Any Type	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0316	Safety Enclosure Frame/Canopy For Use With Hospital Bed Any Type	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0328	Hospital Bed Pediatric Manual 360 Degree Side Enclosures Top Of Headboard	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0329	Hospital Bed Pediatric Electric Or Semi-Electric 360 Degree Side Enclosures	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0373	Nonpowered Advanced Pressure Reducing Mattress	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

E0446	Topical 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.	_	_	_
E0468	Home Ventilator Dual-Function Respiratory Device Also Performs Additional Function Of Cough Stimulation Includes All Accessories Components And Supplies For All Functions	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2024	_	Add effective 4/1/2024
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)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0481	Intrapulmonary Percussive Ventilation System And Related Accessories	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0482	Cough Stimulating Device Alternating Positive And Negative Airway Pressure	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0483	High Frequency Chest Wall Oscillation System With Full Anterior And/Or Posterior Thoracic Region Receiving Simultaneous External Oscillation Includes All Accessories And Supplies Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0484	Oscillatory Positive Expiratory Pressure Device Non-Electric Any Type Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0485	Oral Device/Appliance Used To Reduce Upper Airway Collapsibility Adjustable Or Non-Adjustable Prefabricated Includes Fitting And Adjustment	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0486	Oral Device/Appliance Used To Reduce Upper Airway Collapsibility Adjustable Or Non-Adjustable Custom Fabricated Includes Fitting And Adjustment	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0487	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).	_	_	_

E0490	Power Source And Control Electronics Unit For Oral Device/Appliance For Neuromuscular Electrical Stimulation Of The Tongue Muscle Controlled By Hardware Remote	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
E0491	Oral Device/Appliance For Neuromuscular Electrical Stimulation Of The Tongue Muscle Used In Conjunction With The Power Source And Control Electronics Unit Controlled By Hardware Remote 90-Day 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).	_	_	_
E0492	Power Source And Control Electronics Unit For Oral Device/Appliance For Neuromuscular Electrical Stimulation Of The Tongue Muscle Controlled By Phone Application	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
E0493	Oral Device/Appliance For Neuromuscular Electrical Stimulation Of The Tongue Muscle Used In Conjunction With The Power Source And Control Electronics Unit Controlled By Phone Application 90-Day Supply	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
E0530	Electronic Positional Obstructive Sleep Apnea Treatment With Sensor Includes All Components And Accessories Any Type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
E0616	Implantable Cardiac Event Recorder With Memory Activator And Programmer	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0617	External Defibrillator With Integrated Electrocardiogram Analysis	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0618	Apnea Monitor Without Recording Feature	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0619	Apnea Monitor With Recording Feature	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0620	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	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
E0627	Seat Lift Mechanism Electric Any Type	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0629	Seat Lift Mechanism Non-Electric Any Type	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0635	Patient Lift Electric With Seat Or Sling	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0636	Multipositional Patient Support System With Integrated Lift Patient Accessible Controls	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0637	Combination Sit To Stand Frame/Table System Any Size Including Pediatric With Seat Lift Feature With Or Without Wheels	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0638	Standing Frame/Table System One Position (E.G. Upright Supine Or Prone Stander) Any Size Including Pediatric With Or Without Wheels	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0639	Patient Lift Moveable From Room To Room With Disassembly And Reassembly Includes All Components/Accessories	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

E0640	Patient Lift Fixed System Includes All Components/Accessories	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0641	Standing Frame/Table System Multi-Position (E.G. Three-Way Stander) Any Size Including Pediatric With Or Without Wheels	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0642	Standing Frame/Table System Mobile (Dynamic Stander) Any Size Including Pediatric	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0650	Pneumatic Compressor Non-Segmental Home Model	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0651	Pneumatic Compressor Segmental Home Model Without Calibrated Gradient Pressure	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0652	Pneumatic Compressor Segmental Home Model With Calibrated Gradient Pressure	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0655	Non-Segmental Pneumatic Appliance For Use With Pneumatic Compressor Half Arm	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0656	Segmental Pneumatic Appliance For Use With Pneumatic Compressor Trunk	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0657	Segmental Pneumatic Appliance For Use With Pneumatic Compressor Chest	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

E0660	Non-Segmental Pneumatic Appliance For Use With Pneumatic Compressor Full Leg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0665	Non-Segmental Pneumatic Appliance For Use With Pneumatic Compressor Full Arm	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0666	Non-Segmental Pneumatic Appliance For Use With Pneumatic Compressor Half Leg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0667	Segmental Pneumatic Appliance For Use With Pneumatic Compressor Full Leg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0668	Segmental Pneumatic Appliance For Use With Pneumatic Compressor Full Arm	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0669	Segmental Pneumatic Appliance For Use With Pneumatic Compressor Half Leg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0670	Segmental Pneumatic Appliance For Use With Pneumatic Compressor Integrated 2 Full Legs And Trunk	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0671	Segmental Gradient Pressure Pneumatic Appliance Full Leg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0672	Segmental Gradient Pressure Pneumatic Appliance Full Arm	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

E0673	Segmental Gradient Pressure Pneumatic Appliance Half Leg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0675	Pneumatic Compression Device 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).	_	_	_
E0676	Intermittent Limb Compression Device (Includes All Accessories) Not Otherwise Specified	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
E0677	Non-Pneumatic Sequential Compression Garment Trunk	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0678	Non-Pneumatic Sequential Compression Garment Full Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
E0679	Non-Pneumatic Sequential Compression Garment Half Leg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
E0680	Non-Pneumatic Compression Controller With Sequential Calibrated Gradient Pressure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
E0681	Non-Pneumatic Compression Controller Without Calibrated Gradient Pressure	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
E0682	Non-Pneumatic Sequential Compression Garment Full Arm	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
E0691	Ultraviolet Light Therapy System Includes Bulbs/Lamps Timer And Eye Protection; Treatment Area 2 Square Feet Or Less	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0692	Ultraviolet Light Therapy System Panel Includes Bulbs/Lamps Timer And Eye Protection 4 Foot Panel	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

E0693	Ultraviolet Light Therapy System Panel Includes Bulbs/Lamps Timer And Eye Protection 6 Foot Panel	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0694	Ultraviolet Multidirectional Light Therapy System In 6 Foot Cabinet Includes Bulbs/Lamps Timer And Eye Protection	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0705	Transfer Device Any Type Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
E0720	Transcutaneous Electrical Nerve Stimulation (Tens) Device Two Lead Localized Stimulation	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
E0730	Transcutaneous Electrical Nerve Stimulation (Tens) Device Four Or More Leads For Multiple Nerve Stimulation	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
E0731	Form Fitting Conductive Garment For Delivery Of Tens Or Nmes (With Conductive Fibers Separated From The Patient'S Skin By Layers Of Fabric)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0732	Cranial Electrotherapy Stimulation (Ces) System Any Type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	5/14/2024	Retire effective 05/14/2024
E0732	Cranial Electrotherapy Stimulation (Ces) System Any Type	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024
E0733	Transcutaneous Electrical Nerve Stimulator For Electrical Stimulation Of The Trigeminal Nerve	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
E0734	External Upper Limb Tremor Stimulator Of The Peripheral Nerves Of The Wrist	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	5/14/2024	Retire effective 05/14/2024
E0734	External Upper Limb Tremor Stimulator Of The Peripheral Nerves Of The Wrist	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024
E0735	Non-Invasive Vagus Nerve Stimulator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
E0736	Transcutaneous Tibial Nerve Stimulator	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2024	_	Add effective 4/1/2024
E0739	Rehab System With Interactive Interface Providing Active Assistance In Rehabilitation Therapy Includes All Components And Accessories Motors Microprocessors Sensors	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2024	_	Add effective 4/1/2024

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).	_	_	_
E0744	Neuromuscular Stimulator For Scoliosis	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0746	Electromyography (Emg) Biofeedback Device	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0747	Osteogenesis Stimulator Electrical Non-Invasive Other Than Spinal Applications	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0760	Osteogenesis Stimulator Low Intensity Ultrasound Non-Invasive	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0761	Non-Thermal Pulsed High Frequency Radiowaves High Peak Power Electromagnetic Energy Treatment Device	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0762	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).	_	_	_
E0764	Functional Neuromuscular Stimulation Transcutaneous Stimulation Of Sequential Muscle Groups Of Ambulation With Computer Control Used For Walking By Spinal Cord Injured Entire System After Completion Of Training Program	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
E0766	Electrical Stimulation Device Used For Cancer Treatment Includes All Accessories Any Type	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0769	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).	_	_	_

E0770	Functional Electrical Stimulator Transcutaneous Stimulation Of Nerve And/Or Muscle Groups Any Type Complete System Not Otherwise Specified	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
E0782	Infusion Pump Implantable Non-Programmable (Includes All Components E. G. Pump Catheter Connectors Etc.)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0783	Infusion Pump System Implantable Programmable (Includes All Components E. G. Pump Catheter Connectors Etc.)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0784	External Ambulatory Infusion Pump Insulin	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0785	Implantable Intraspinal (Epidural/Intrathecal) Catheter Used With Implantable Infusion Pump Replacement	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0786	Implantable Programmable Infusion Pump Replacement (Excludes Implantable Intraspinal Catheter)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0787	External Ambulatory Infusion Pump Insulin Dosage Rate Adjustment Using Therapeutic Continuous Glucose Sensing	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0830	Ambulatory Traction Device 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).	_	_	_
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).	_	_	_
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).	_	_	_

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).	_	_	_
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).	_	_	_
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).	_	_	_
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).	_	_	_
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).	_	_	_
E0920	Fracture Frame Attached To Bed Includes Weights	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0930	Fracture Frame Free Standing Includes Weights	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0935	Continuous Passive Motion Exercise Device For Use On Knee Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0936	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).	_	_	_
E0941	Gravity Assisted Traction Device Any Type	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

E0942	Cervical Head Harness/Halter	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
E0944	Pelvic Belt/Harness/Boot	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
E0946	Fracture Frame Dual With Cross Bars Attached To Bed (E. G. Balken 4 Poster)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0947	Fracture Frame Attachments For Complex Pelvic Traction	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0948	Fracture Frame Attachments For Complex Cervical Traction	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0950	Wheelchair Accessory Tray Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0953	Wheelchair Accessory Lateral Thigh Or Knee Support Any Type Including Fixed Mounting Hardware Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0954	Wheelchair Accessory Foot Box Any Type Includes Attachment And Mounting Hardware Each Foot	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0955	Wheelchair Accessory Headrest Cushioned Any Type Including Fixed Mounting Hardware Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

E0969	Narrowing Device Wheelchair	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0981	Wheelchair Accessory Seat Upholstery Replacement Only Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0982	Wheelchair Accessory Back Upholstery Replacement Only Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0983	Manual Wheelchair Accessory Power Add-On To Convert Manual Wheelchair To Motorized Wheelchair Joystick Control	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0984	Manual Wheelchair Accessory Power Add-On To Convert Manual Wheelchair To Motorized Wheelchair Tiller Control	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0985	Wheelchair Accessory Seat Lift Mechanism	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0986	Manual Wheelchair Accessory Push-Rim Activated Power Assist System	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0988	Manual Wheelchair Accessory Lever-Activated Wheel Drive Pair	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E0990	Wheelchair Accessory Elevating Leg Rest Complete Assembly Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

E0992	Manual Wheelchair Accessory Solid Seat Insert	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1002	Wheelchair Accessory Power Seating System Tilt Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1003	Wheelchair Accessory Power Seating System Recline Only Without Shear Reduction	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1004	Wheelchair Accessory Power Seating System Recline Only With Mechanical Shear Reduction	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1005	Wheelchair Accessory Power Seatng System Recline Only With Power Shear Reduction	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1006	Wheelchair Accessory Power Seating System Combination Tilt And Recline Without Shear Reduction	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1007	Wheelchair Accessory Power Seating System Combination Tilt And Recline With Mechanical Shear Reduction	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1008	Wheelchair Accessory Power Seating System Combination Tilt And Recline With Power Shear Reduction	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1009	Wheelchair Accessory Addition To Power Seating System Mechanically Linked Leg Elevation System Including Pushrod And Leg Rest Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

E1010	Wheelchair Accessory Addition To Power Seating System Power Leg Elevation System Including Leg Rest Pair	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1012	Wheelchair Accessory Addition To Power Seating System Center Mount Power Elevating Leg Rest/Platform Complete System Any Type Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1028	Wheelchair Accessory Manual Swingaway Retractable Or Removable Mounting Hardware For Joystick Other Control Interface Or Positioning Accessory	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1031	Rollabout Chair Any And All Types With Castors 5 Or Greater	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1035	Multi-Positional Patient Transfer System With Integrated Seat Operated By Care Giver Patient Weight Capacity Up To And Including 300 Lbs	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1036	Multi-Positional Patient Transfer System Extra-Wide With Integrated Seat Operated By Caregiver Patient Weight Capacity Greater Than 300 Lbs	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1037	Transport Chair Pediatric Size	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1038	Transport Chair Adult Size Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1039	Transport Chair Adult Size Heavy Duty Patient Weight Capacity Greater Than 300 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

E1050	Fully-Reclining Wheelchair Fixed Full Length Arms Swing Away Detachable Elevating Leg Rests	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1060	Fully-Reclining Wheelchair Detachable Arms Desk Or Full Length Swing Away Detachable Elevating Legrests	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1070	Fully-Reclining Wheelchair Detachable Arms (Desk Or Full Length) Swing Away Detachable Footrest	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1083	Hemi-Wheelchair Fixed Full Length Arms Swing Away Detachable Elevating Leg Rest	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1084	Hemi-Wheelchair Detachable Arms Desk Or Full Length Arms Swing Away Detachable Elevating Leg Rests	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1085	Hemi-Wheelchair Fixed Full Length Arms Swing Away Detachable Foot Rests	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1086	Hemi-Wheelchair Detachable Arms Desk Or Full Length Swing Away Detachable Footrests	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1087	High Strength Lightweight Wheelchair Fixed Full Length Arms Swing Away Detachable Elevating Leg Rests	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1088	High Strength Lightweight Wheelchair Detachable Arms Desk Or Full Length Swing Away Detachable Elevating Leg Rests	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

E1089	High Strength Lightweight Wheelchair Fixed Length Arms Swing Away Detachable Footrest	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1090	High Strength Lightweight Wheelchair Detachable Arms Desk Or Full Length Swing Away Detachable Foot Rests	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1092	Wide Heavy Duty Wheel Chair Detachable Arms (Desk Or Full Length) Swing Away Detachable Elevating Leg Rests	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1093	Wide Heavy Duty Wheelchair Detachable Arms Desk Or Full Length Arms Swing Away Detachable Footrests	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1100	Semi-Reclining Wheelchair Fixed Full Length Arms Swing Away Detachable Elevating Leg Rests	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1110	Semi-Reclining Wheelchair Detachable Arms (Desk Or Full Length) Elevating Leg Rest	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1130	Standard Wheelchair Fixed Full Length Arms Fixed Or Swing Away Detachable Footrests	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1140	Wheelchair Detachable Arms Desk Or Full Length Swing Away Detachable Footrests	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1150	Wheelchair Detachable Arms Desk Or Full Length Swing Away Detachable Elevating Legrests	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

E1160	Wheelchair Fixed Full Length Arms Swing Away Detachable Elevating Legrests	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1161	Manual Adult Size Wheelchair Includes Tilt In Space	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1170	Amputee Wheelchair Fixed Full Length Arms Swing Away Detachable Elevating Legrests	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1171	Amputee Wheelchair Fixed Full Length Arms Without Footrests Or Legrest	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1172	Amputee Wheelchair Detachable Arms (Desk Or Full Length) Without Footrests Or Legrest	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1180	Amputee Wheelchair Detachable Arms (Desk Or Full Length) Swing Away Detachable Footrests	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1190	Amputee Wheelchair Detachable Arms (Desk Or Full Length) Swing Away Detachable Elevating Legrests	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1195	Heavy Duty Wheelchair Fixed Full Length Arms Swing Away Detachable Elevating Legrests	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1200	Amputee Wheelchair Fixed Full Length Arms Swing Away Detachable Footrest	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

E1220	Wheelchair; Specially Sized Or Constructed (Indicate Brand Name Model Number If Any) And Justification	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1221	Wheelchair With Fixed Arm Footrests	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1222	Wheelchair With Fixed Arm Elevating Legrests	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1223	Wheelchair With Detachable Arms Footrests	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1224	Wheelchair With Detachable Arms Elevating Legrests	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1225	Wheelchair Accessory Manual Semi-Reclining Back (Recline Greater Than 15 Degrees But Less Than 80 Degrees) Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1226	Wheelchair Accessory Manual Fully Reclining Back (Recline Greater Than 80 Degrees) Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1227	Special Height Arms For Wheelchair	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1228	Special Back Height For Wheelchair	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

E1229	Wheelchair Pediatric Size Not Otherwise Specified	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
E1230	Power Operated Vehicle (Three Or Four Wheel Nonhighway) Specify Brand Name And Model Number	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1231	Wheelchair Pediatric Size Tilt-In-Space Rigid Adjustable With Seating System	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1232	Wheelchair Pediatric Size Tilt-In-Space Folding Adjustable With Seating System	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1233	Wheelchair Pediatric Size Tilt-In-Space Rigid Adjustable Without Seating System	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1234	Wheelchair Pediatric Size Tilt-In-Space Folding Adjustable Without Seating System	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1235	Wheelchair Pediatric Size Rigid Adjustable With Seating System	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1236	Wheelchair Pediatric Size Folding Adjustable With Seating System	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

E1237	Wheelchair Pediatric Size Rigid Adjustable Without Seating System	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1238	Wheelchair Pediatric Size Folding Adjustable Without Seating System	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1239	Power Wheelchair Pediatric Size Not Otherwise Specified	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
E1240	Lightweight Wheelchair Detachable Arms (Desk Or Full Length) Swing Away Detachable Elevating Legrest	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1250	Lightweight Wheelchair Fixed Full Length Arms Swing Away Detachable Footrest	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1260	Lightweight Wheelchair Detachable Arms (Desk Or Full Length) Swing Away Detachable Footrest	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1270	Lightweight Wheelchair Fixed Full Length Arms Swing Away Detachable Elevating Legrests	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1280	Heavy Duty Wheelchair Detachable Arms (Desk Or Full Length) Elevating Legrests	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

E1285	Heavy Duty Wheelchair Fixed Full Length Arms Swing Away Detachable Footrest	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1290	Heavy Duty Wheelchair Detachable Arms (Desk Or Full Length) Swing Away Detachable Footrest	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1295	Heavy Duty Wheelchair Fixed Full Length Arms Elevating Legrest	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1296	Special Wheelchair Seat Height From Floor	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1297	Special Wheelchair Seat Depth By Upholstery	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1298	Special Wheelchair Seat Depth And/Or Width By Construction	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E1300	Whirlpool Portable (Overtub Type)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
E1301	Whirlpool Tub Walk-In Portable	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
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	Tablo Hemodialysis System For The Billable Dialysis Service	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

E1632	Wearable Artificial Kidney 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).	_	_	_
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).	_	_	_
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).	_	_	_
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).	_	_	_
E1902	Communication Board Non-Electronic Augmentative Or Alternative Communication Device	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
E1905	Virtual Reality Cognitive Behavioral Therapy Device (Cbt) Including Pre-Programmed Therapy Software	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2120	Pulse Generator System For Tympanic Treatment Of Inner Ear Endolymphatic Fluid	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2201	Manual Wheelchair Accessory Nonstandard Seat Frame Width Greater Than Or Equal To 20 Inches And Less Than 24 Inches	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2202	Manual Wheelchair Accessory Nonstandard Seat Frame Width 24-27 Inches	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2203	Manual Wheelchair Accessory Nonstandard Seat Frame Depth 20 To Less Than 22 Inches	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

E2204	Manual Wheelchair Accessory Nonstandard Seat Frame Depth 22 To 25 Inches	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2206	Manual Wheelchair Accessory Wheel Lock Assembly Complete Replacement Only Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2207	Wheelchair Accessory Crutch And Cane Holder Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2209	Arm Trough With Or Without Hand Support Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2211	Manual Wheelchair Accessory Pneumatic Propulsion Tire Any Size Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2212	Manual Wheelchair Accessory Tube For Pneumatic Propulsion Tire Any Size Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2213	Manual Wheelchair Accessory Insert For Pneumatic Propulsion Tire (Removable) Any Type Any Size Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2214	Manual Wheelchair Accessory Pneumatic Caster Tire Any Size Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2215	Manual Wheelchair Accessory Tube For Pneumatic Caster Tire Any Size Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

E2216	Manual Wheelchair Accessory Foam Filled Propulsion Tire Any Size Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2217	Manual Wheelchair Accessory Foam Filled Caster Tire Any Size Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2218	Manual Wheelchair Accessory Foam Propulsion Tire Any Size Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2219	Manual Wheelchair Accessory Foam Caster Tire Any Size Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2220	Manual Wheelchair Accessory Solid (Rubber/Plastic) Propulsion Tire Any Size Replacement Only Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2221	Manual Wheelchair Accessory Solid (Rubber/Plastic) Caster Tire (Removable) Any Size Replacement Only Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2222	Manual Wheelchair Accessory Solid (Rubber/Plastic) Caster Tire With Integrated Wheel Any Size Replacement Only Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2228	Manual Wheelchair Accessory Wheel Braking System And Lock Complete Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2230	Manual Wheelchair Accessory Manual Standing System	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

E2231	Manual Wheelchair Accessory Solid Seat Support Base (Replaces Sling Seat) Includes Any Type Mounting Hardware	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2291	Back Planar For Pediatric Size Wheelchair Including Fixed Attaching Hardware	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2292	Seat Planar For Pediatric Size Wheelchair Including Fixed Attaching Hardware	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2293	Back Contoured For Pediatric Size Wheelchair Including Fixed Attaching Hardware	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2294	Seat Contoured For Pediatric Size Wheelchair Including Fixed Attaching Hardware	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2295	Manual Wheelchair Accessory For Pediatric Size Wheelchair Dynamic Seating Frame Allows Coordinated Movement Of Multiple Positioning Features	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2298	Complex Rehabilitative Power Wheelchair Accessory Power Seat Elevation System Any Type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2024	_	Add effectuce 04/01/2024
E2300	Wheelchair accessory, power seat elevation system, any type	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	3/31/2024	Retire effective 03/31/2024
E2301	Wheelchair Accessory Power Standing System Any Type	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

E2310	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	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2311	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	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2312	Power Wheelchair Accessory Hand Or Chin Control Interface Mini-Proportional	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2313	Power Wheelchair Accessory Harness For Upgrade To Expandable Controller	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2321	Power Wheelchair Accessory Hand Control Interface Remote Joystick Nonproportional Including All Related Electronics Mechanical Stop Switch And Fixed Mounting Hardware	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2322	Power Wheelchair Accessory Hand Control Interface Multiple Mechanical Switches Nonproportional Including All Related Electronics Mechanical Stop Switch And Fixed Mounting Hardware	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2323	Power Wheelchair Accessory Specialty Joystick Handle For Hand Control Interface Prefabricated	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2324	Power Wheelchair Accessory Chin Cup For Chin Control Interface	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2325	Power Wheelchair Accessory Sip And Puff Interface Nonproportional Including All Related Electronics Mechanical Stop Switch And Manual Swingaway Mounting Hardware	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

E2326	Power Wheelchair Accessory Breath Tube Kit For Sip And Puff Interface	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2327	Power Wheelchair Accessory Head Control Interface Mechanical Proportional Including All Related Electronics Mechanical Direction Change Switch And Fixed Mounting Hardware	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2328	Power Wheelchair Accessory Head Control Or Extremity Control Interface Electronic Proportional Including All Related Electronics And Fixed Mounting Hardware	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2329	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	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2330	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	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2331	Power Wheelchair Accessory Attendant Control Proportional Including All Related Electronics And Fixed Mounting Hardware	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2340	Power Wheelchair Accessory Nonstandard Seat Frame Width 20-23 Inches	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2341	Power Wheelchair Accessory Nonstandard Seat Frame Width 24-27 Inches	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2342	Power Wheelchair Accessory Nonstandard Seat Frame Depth 20 Or 21 Inches	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

E2343	Power Wheelchair Accessory Nonstandard Seat Frame Depth 22-25 Inches	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2351	Power Wheelchair Accessory Electronic Interface To Operate Speech Generating Device Using Power Wheelchair Control Interface	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2358	Power Wheelchair Accessory Group 34 Non-Sealed Lead Acid Battery Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2359	Power Wheelchair Accessory Group 34 Sealed Lead Acid Battery Each (E.G. Gel Cell Absorbed Glassmat)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2360	Power Wheelchair Accessory 22 Nf Non-Sealed Lead Acid Battery Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2361	Power Wheelchair Accessory 22Nf Sealed Lead Acid Battery Each (E. G. Gel Cell Absorbed Glassmat)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2362	Power Wheelchair Accessory Group 24 Non-Sealed Lead Acid Battery Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2363	Power Wheelchair Accessory Group 24 Sealed Lead Acid Battery Each (E. G. Gel Cell Absorbed Glassmat)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2364	Power Wheelchair Accessory U-1 Non-Sealed Lead Acid Battery Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

E2365	Power Wheelchair Accessory U-1 Sealed Lead Acid Battery Each (E. G. Gel Cell Absorbed Glassmat)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2366	Power Wheelchair Accessory Battery Charger Single Mode For Use With Only One Battery Type Sealed Or Non-Sealed Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2367	Power Wheelchair Accessory Battery Charger Dual Mode For Use With Either Battery Type Sealed Or Non-Sealed Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2371	Power Wheelchair Accessory Group 27 Sealed Lead Acid Battery (E.G. Gel Cell Absorbed Glassmat) Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2372	Power Wheelchair Accessory Group 27 Non-Sealed Lead Acid Battery Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2373	Power Wheelchair Accessory Hand Or Chin Control Interface Compact Remote Joystick Proportional Including Fixed Mounting Hardware	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2374	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	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2375	Power Wheelchair Accessory Non-Expandable Controller Including All Related Electronics And Mounting Hardware Replacement Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2376	Power Wheelchair Accessory Expandable Controller Including All Related Electronics And Mounting Hardware Replacement Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

E2377	Power Wheelchair Accessory Expandable Controller Including All Related Electronics And Mounting Hardware Upgrade Provided At Initial Issue	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2397	Power Wheelchair Accessory Lithium-Based Battery Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2402	Negative Pressure Wound Therapy Electrical Pump Stationary Or Portable	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2500	Speech Generating Device Digitized Speech Using Pre-Recorded Messages Less Than Or Equal To 8 Minutes Recording Time	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2502	Speech Generating Device Digitized Speech Using Pre-Recorded Messages Greater Than 8 Minutes But Less Than Or Equal To 20 Minutes Recording Time	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2504	Speech Generating Device Digitized Speech Using Pre-Recorded Messages Greater Than 20 Minutes But Less Than Or Equal To 40 Minutes Recording Time	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2506	Speech Generating Device Digitized Speech Using Pre-Recorded Messages Greater Than 40 Minutes Recording Time	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2508	Speech Generating Device Synthesized Speech Requiring Message Formulation By Spelling And Access By Physical Contact With The Device	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2510	Speech Generating Device Synthesized Speech Permitting Multiple Methods Of Message Formulation And Multiple Methods Of Device Access	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

E2511	Speech Generating Software Program For Personal Computer Or Personal Digital Assistant	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2512	Accessory For Speech Generating Device Mounting System	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2599	Accessory For Speech Generating Device Not Otherwise Classified	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
E2602	General Use Wheelchair Seat Cushion Width 22 Inches Or Greater Any Depth	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2603	Skin Protection Wheelchair Seat Cushion Width Less Than 22 Inches Any Depth	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2604	Skin Protection Wheelchair Seat Cushion Width 22 Inches Or Greater Any Depth	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2605	Positioning Wheelchair Seat Cushion Width Less Than 22 Inches Any Depth	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2606	Positioning Wheelchair Seat Cushion Width 22 Inches Or Greater Any Depth	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

E2607	Skin Protection And Positioning Wheelchair Seat Cushion Width Less Than 22 Inches Any Depth	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2608	Skin Protection And Positioning Wheelchair Seat Cushion Width 22 Inches Or Greater Any Depth	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2609	Custom Fabricated Wheelchair Seat Cushion Any Size	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2610	Wheelchair Seat Cushion Powered	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2611	General Use Wheelchair Back Cushion Width Less Than 22 Inches Any Height Including Any Type Mounting Hardware	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2612	General Use Wheelchair Back Cushion Width 22 Inches Or Greater Any Height Including Any Type Mounting Hardware	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2613	Positioning Wheelchair Back Cushion Posterior Width Less Than 22 Inches Any Height Including Any Type Mounting Hardware	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2614	Positioning Wheelchair Back Cushion Posterior Width 22 Inches Or Greater Any Height Including Any Type Mounting Hardware	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2615	Positioning Wheelchair Back Cushion Posterior-Lateral Width Less Than 22 Inches Any Height Including Any Type Mounting Hardware	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

E2616	Positioning Wheelchair Back Cushion Posterior-Lateral Width 22 Inches Or Greater Any Height Including Any Type Mounting Hardware	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2617	Custom Fabricated Wheelchair Back Cushion Any Size Including Any Type Mounting Hardware	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2620	Positioning Wheelchair Back Cushion Planar Back With Lateral Supports Width Less Than 22 Inches Any Height Including Any Type Mounting Hardware	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2621	Positioning Wheelchair Back Cushion Planar Back With Lateral Supports Width 22 Inches Or Greater Any Height Including Any Type Mounting Hardware	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2622	Skin Protection Wheelchair Seat Cushion Adjustable Width Less Than 22 Inches Any Depth	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2623	Skin Protection Wheelchair Seat Cushion Adjustable Width 22 Inches Or Greater Any Depth	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2624	Skin Protection And Positioning Wheelchair Seat Cushion Adjustable Width Less Than 22 Inches Any Depth	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2625	Skin Protection And Positioning Wheelchair Seat Cushion Adjustable Width 22 Inches Or Greater Any Depth	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2626	Wheelchair Accessory Shoulder Elbow Mobile Arm Support Attached To Wheelchair Balanced Adjustable	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

E2627	Wheelchair Accessory Shoulder Elbow Mobile Arm Support Attached To Wheelchair Balanced Adjustable Rancho Type	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2628	Wheelchair Accessory Shoulder Elbow Mobile Arm Support Attached To Wheelchair Balanced Reclining	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2629	Wheelchair Accessory Shoulder Elbow Mobile Arm Support Attached To Wheelchair Balanced Friction Arm Support (Friction Dampening To Proximal And Distal Joints)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2630	Wheelchair Accessory Shoulder Elbow Mobile Arm Support Monosuspension Arm And Hand Support Overhead Elbow Forearm Hand Sling Support Yoke Type Suspension Support	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2631	Wheelchair Accessory Addition To Mobile Arm Support Elevating Proximal Arm	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2632	Wheelchair Accessory Addition To Mobile Arm Support Offset Or Lateral Rocker Arm With Elastic Balance Control	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E2633	Wheelchair Accessory Addition To Mobile Arm Support Supinator	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
E3000	Speech Volume Modulation System Any Type Including All Components And Accessories	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	5/14/2024	Retire effective 05/14/2024
E3000	Speech Volume Modulation System Any Type Including All Components And Accessories	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024
G0127	Trimming Of Dystrophic Nails Any Number	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

G0138	Intravenous Infusion Of Cipaglucosidase Alfa-Atga Including Provider/Supplier Acquisition And Clinical Supervision Of Oral Administration Of Miglustat In Preparation Of Receipt Of Cipaglucosidase Alfa-Atga	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2024	_	Add effective 4/1/2024
G0151	Services Performed By A Qualified Physical Therapist In The Home Health Or Hospice Setting Each 15 Minutes	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
G0152	Services Performed By A Qualified Occupational Therapist In The Home Health Or Hospice Setting Each 15 Minutes	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
G0153	Services Performed By A Qualified Speech-Language Pathologist In The Home Health Or Hospice Setting Each 15 Minutes	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
G0157	Services Performed By A Qualified Physical Therapist Assistant In The Home Health Or Hospice Setting Each 15 Minutes	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
G0158	Services Performed By A Qualified Occupational Therapist Assistant In The Home Health Or Hospice Setting Each 15 Minutes	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
G0159	Services Performed By A Qualified Physical Therapist In The Home Health Setting In The Establishment Or Delivery Of A Safe And Effective Physical Therapy Maintenance Program Each 15 Minutes	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
G0160	Services Performed By A Qualified Occupational Therapist In The Home Health Setting In The Establishment Or Delivery Of A Safe And Effective Occupational Therapy Maintenance Program Each 15 Minutes	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
G0161	Services Performed By A Qualified Speech-Language Pathologist In The Home Health Setting In The Establishment Or Delivery Of A Safe And Effective Speech-Language Pathology Maintenance Program Each 15 Minutes	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

G0166	External Counterpulsation Per Treatment Session	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
G0176	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)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
G0177	Training And Educational Services Related To The Care And Treatment Of Patient'S Disabling Mental Health Problems Per Session (45 Minutes Or More)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
G0235	Pet Imaging Any Site Not Otherwise Specified	Unlisted Procedure; May require Prior Authorization per contract agreement.	_	_	_
G0255	Current 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).	_	_	_
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.	_	_	_
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).	_	_	_
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).	_	_	_
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).	_	_	_
G0302	Pre-Operative Pulmonary Surgery Services For Preparation For Lvrs Complete Course Of Services To Include A Minimum Of 16 Days Of Services	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
G0303	Pre-Operative Pulmonary Surgery Services For Preparation For Lvrs 10 To 15 Days Of Services	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
G0304	Pre-Operative Pulmonary Surgery Services For Preparation For Lvrs 1 To 9 Days Of Services	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
G0305	Post-Discharge Pulmonary Surgery Services After Lvrs Minimum Of 6 Days Of Services	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
G0310	Immunization Counseling By A Physician Or Other Qualified Health Care Professional When The Vaccine(S) Is Not Administered On The Same Date Of Service 5 To 15 Mins Time (This Code Is Used For Medicaid Billing Purposes)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G0311	Immunization Counseling By A Physician Or Other Qualified Health Care Professional When The Vaccine(S) Is Not Administered On The Same Date Of Service 16-30 Mins Time (This Code Is Used For Medicaid Billing Purposes)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G0312	Immunization Counseling By A Physician Or Other Qualify Ed Health Care Professional When The Vaccine(S) Is Not Administered On The Same Date Of Service For Ages Under 21 5 To 15 Mins Time (This Code Is Used For Medicaid Billing Purposes)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G0313	Immunization Counseling By A Physician Or Other Qualified Health Care Professional When The Vaccine(S) Is Not Administered On The Same Date Of Service For Ages Under 21 16-30 Mins Time (This Code Is Used For Medicaid Billing Purposes)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_

G0314	Immunization Counseling By A Physician Or Other Qualified Health Care Professional For Covid-19 Ages Under 21 16-30 Mins Time (This Code Is Used For The Medicaid Early And Periodic Screening Diagnostic And Treatment Benefit (Epsdt)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G0315	Immunization Counseling By A Physician Or Other Qualified Health Care Professional For Covid-19 Ages Under 21 5-15 Mins Time (This Code Is Used For The Medicaid Early And Periodic Screening Diagnostic And Treatment Benefit (Epsdt)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G0316	Prolonged Hospital Inpatient Or Observation Care Evaluation And Management Service(S) Beyond The Total Time For The Primary Service (When The Primary Service Has Been Selected Using Time On The Date Of The Primary Service); Each Additional 15 Minutes By The Physician Or Qualified Healthcare Professional With Or Without Direct Patient Contact (List Separately In Addition To Cpt Codes 99223 99233 And 99236 For Hospital Inpatient Or Observation Care Evaluation And Management Services). (Do Not Report G0316 On The Same Date Of Service As Other Prolonged Services For Evaluation And Management 99358 99359 99418 99415 99416). (Do Not Report G0316 For Any Time Unit Less Than 15 Minutes)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G0317	Prolonged Nursing Facility Evaluation And Management Service(S) Beyond The Total Time For The Primary Service (When The Primary Service Has Been Selected Using Time On The Date Of The Primary Service); Each Additional 15 Minutes By The Physician Or Qualified Healthcare Professional With Or Without Direct Patient Contact (List Separately In Addition To Cpt Codes 99306 99310 For Nursing Facility Evaluation And Management Services). (Do Not Report G0317 On The Same Date Of Service As Other Prolonged Services For Evaluation And Management 99358 99359 99418). (Do Not Report G0317 For Any Time Unit Less Than 15 Minutes)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_

G0318	Prolonged Home Or Residence Evaluation And Management Service(S) Beyond The Total Time For The Primary Service (When The Primary Service Has Been Selected Using Time On The Date Of The Primary Service); Each Additional 15 Minutes By The Physician Or Qualified Healthcare Professional With Or Without Direct Patient Contact (List Separately In Addition To Cpt Codes 99345 99350 For Home Or Residence Evaluation And Management Services). (Do Not Report G0318 On The Same Date Of Service As Other Prolonged Services For Evaluation And Management 99358 99359 99417). (Do Not Report G0318 For Any Time Unit Less Than 15 Minutes)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
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).	_	_	_
G0330	Facility Services For Dental Rehabilitation Procedure(S) Performed On A Patient Who Requires Monitored Anesthesia (E.G. General Intravenous Sedation (Monitored Anesthesia Care) And Use Of An Operating Room	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
G0333	Pharmacy Dispensing Fee For Inhalation Drug(S); Initial 30-Day Supply As A Beneficiary	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
G0341	Percutaneous Islet Cell Transplant Includes Portal Vein Catheterization And Infusion	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
G0342	Laparoscopy For Islet Cell Transplant Includes Portal Vein Catheterization And Infusion	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
G0343	Laparotomy For Islet Cell Transplant Includes Portal Vein Catheterization And Infusion	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
G0372	Physician Service Required To Establish And Document The Need For A Power Mobility Device (Use In Addition To Primary Evaluation And Management Code)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_

G0422	Intensive Cardiac Rehabilitation; With Or Without Continuous Ecg Monitoring With Exercise Per Session	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
G0423	Intensive Cardiac Rehabilitation; With Or Without Continuous Ecg Monitoring; Without Exercise Per Session	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
G0428	Collagen Meniscus Implant Procedure For Filling Meniscal Defects (E.G. Cmi Collagen Scaffold Menaflex)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
G0429	Dermal Filler Injection(S) For The Treatment Of Facial Lipodystrophy Syndrome (Lds) (E.G. As A Result Of Highly Active Antiretroviral Therapy.)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
G0448	Insertion Or Replacement Of A Permanent Pacing Cardioverter-Defibrillator System With Transvenous Lead(S) Single Or Dual Chamber With Insertion Of Pacing Electrode Cardiac Venous System For Left Ventricular Pacing	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
G0455	Preparation With Instillation Of Fecal Microbiota By Any Method Including Assessment Of Donor Specimen	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
G0460	Autologous Platelet Rich Plasma Or Other Blood-Derived Product For Non-Diabetic Chronic Wounds/Ulcers Including As Applicable Phlebotomy Centrifugation Or Mixing And All Other Preparatory Procedures Administration And Dressings 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).	_	_	_
G0465	Autologous Platelet Rich Plasma (Prp) Or Other Blood-Derived Product For Diabetic Chronic Wounds/Ulcers Using An Fda-Cleared Device For This Indication (Includes As Applicable Administration Dressings Phlebotomy Centrifugation Or Mixing And All Other Preparatory Procedures 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).	_	_	_
G0516	Insertion Of Non-Biodegradable Drug Delivery Implants 4 Or More (Services For Subdermal Rod Implant)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

G0517	Removal Of Non-Biodegradable Drug Delivery Implants 4 Or More (Services For Subdermal Implants)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
G0518	Removal With Reinsertion Non-Biodegradable Drug Delivery Implants 4 Or More (Services For Subdermal Implants)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
G2011	Alcohol And/Or Substance (Other Than Tobacco) Misuse Structured Assessment (E.G. Audit Dast) And Brief Intervention 5-14 Minutes	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
G2082	Office Or Other Outpatient Visit For The Evaluation And Management Of An Established Patient That Requires The Supervision Of A Physician Or Other Qualified Health Care Professional And Provision Of Up To 56 Mg Of Esketamine Nasal Self-Administration Includes 2 Hours Post-Administration Observation	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
G2083	Office Or Other Outpatient Visit For The Evaluation And Management Of An Established Patient That Requires The Supervision Of A Physician Or Other Qualified Health Care Professional And Provision Of Greater Than 56 Mg Esketamine Nasal Self-Administration Includes 2 Hours Post-Administration Observation	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
G3002	Chronic Pain Management And Treatment Monthly Bundle Including Diagnosis; Assessment And Monitoring; Administration Of A Validated Pain Rating Scale Or Tool; The Development Implementation Revision And/Or Maintenance Of A Person-Centered Care Plan That Includes Strengths Goals Clinical Needs And Desired Outcomes; Overall Treatment Management; Facilitation And Coordination Of Any Necessary Behavioral Health Treatment; Medication Management; Pain And Health Literacy Counseling; Any Necessary Chronic Pain Related Crisis Care; And Ongoing Communication And Care Coordination Between Relevant Practitioners Furnishing Care E.G. Physical Therapy And Occupational Therapy Complementary And Integrative Approaches And Community-Based Care As Appropriate. Required Initial Face-To-Face Visit At Least 30 Minutes Provided By A Physician Or Other Qualified Health Professional; First 30 Minutes Personally Provided By Physician Or Other Qualified Health Care Professional Per Calendar Month. (When Using G3002 30 Minutes Must Be Met Or Exceeded.)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_

G3003	Each Additional 15 Minutes Of Chronic Pain Management And Treatment By A Physician Or Other Qualified Health Care Professional Per Calendar Month. (List Separately In Addition To Code For G3002. When Using G3003 15 Minutes Must Be Met Or Exceeded.)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
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.	_	_	_
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	Documentation Of A Medical Reason(S) For Not Documenting Updating Or Reviewing The Patient'S Current Medications List (E.G. Patient Is In An Urgent Or Emergent Medical Situation)	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 Patient Or Medical 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)	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 (E.G. Allergy Intolerance Pregnancy Renal Failure Due To Ace Inhibitor Diseases Of The Aortic Or Mitral Valve Other Medical Reasons) Or (E.G. Patient Declined Other Patient Reasons)	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 the Plan. Not subject to utilization review. Unlisted or Undefined	_	_	_
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.	_	_	_
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).	_	_	_
G9886	Behavioral Counseling For Diabetes Prevention In-Person Group 60 Minutes	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
G9887	Behavioral Counseling For Diabetes Prevention Distance Learning 60 Minutes	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024

G9888	Maintenance 5% Wl From Baseline Weight In Months 7-12	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
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.	_	_	_
H0051	Traditional Healing Service	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	4/1/2024	_	Add effective 4/1/2024
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)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J0172	Injection Aducanumab-Avwa 2 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J0174	Injection Lecanemab-Irmb 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J0177	Injection Aflibercept Hd 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2024	_	Add effective 4/1/2024
J0178	Injection Aflibercept 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J0179	Injection Brolucizumab-Dbll 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J0202	Injection Alemtuzumab 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	5/31/2024	Retire effective 5/31/2024
J0215	Injection Alefacept 0. 5 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J0217	Injection Velmanase Alfa-Tycv 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024

J0218	Injection Olipudase Alfa-Rpcp 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J0219	Injection Avalglucosidase Alfa-Ngpt 4 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J0220	Injection Alglucosidase Alfa 10 Mg Not Otherwise Specified	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
J0222	Injection Patisiran 0.1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J0223	Injection Givosiran 0.5 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J0224	Injection Lumasiran 0.5 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J0225	Injection Vutrisiran 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J0248	Injection Remdesivir 1Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	5/1/2024	_	Add effective 5/1/2024

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)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J0275	Alprostadil Urethral 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)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J0470	Injection Dimercaprol Per 100 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J0485	Injection Belatacept 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	3/1/2024	_	Add effective 03/01/2024
J0490	Injection Belimumab 10 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J0491	Injection Anifrolumab-Fnia 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J0517	Injection Benralizumab 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J0565	Injection Bezlotoxumab 10 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_

J0567	Injection Cerliponase Alfa 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J0584	Injection Burosumab-Twza 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J0585	Injection Onabotulinumtoxina 1 Unit	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J0586	Injection Abobotulinumtoxina 5 Units	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J0587	Injection Rimabotulinumtoxinb 100 Units	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	1/31/2024	Retire effective 01/31/2024
J0588	Injection Incobotulinumtoxin A 1 Unit	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	1/31/2024	Retire effective 01/31/2024
J0589	Injection Daxibotulinumtoxina-Lanm 1 Unit	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2024	_	Add effective 4/1/2024
J0600	Injection Edetate Calcium Disodium Up To 1000 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

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)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J0739	Injection, cabotegravir, 1mg, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment for hiv)	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	3/14/2024	Retire effective 03/14/2024
J0741	Injection Cabotegravir And Rilpivirine 2Mg/3Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	6/30/2024	Retire effective 06/30/2024
J0775	Injection Collagenase Clostridium Histolyticum 0.01 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J0791	Injection Crizanlizumab-Tmca 5 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J0881	Injection Darbepoetin Alfa 1 Microgram (Non-Esrd Use)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J0895	Injection Deferoxamine Mesylate 500 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J1071	Injection Testosterone Cypionate 1Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J1203	Injection Cipaglucosidase Alfa-Atga 5 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2024	_	Add effective 4/1/2024

J1301	Injection Edaravone 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J1302	Injection Sutimlimab-Jome 10 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J1303	Injection Ravulizumab-Cwvz 10 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J1304	Injection Tofersen 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
J1305	Injection Evinacumab-Dgnb 5Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J1306	Injection Inclisiran 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J1323	Injection Elranatamab-Bcmm 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2024	_	Add effective 4/1/2024
J1325	Injection Epoprostenol 0. 5 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J1411	Injection Etranacogene Dezaparvovec-Drlb Per Therapeutic Dose	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

J1412	Injection Valoctocogene Roxaparvovec-Rvox Per Ml Containing Nominal 2 X 10^13 Vector Genomes	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
J1413	Injection Delandistrogene Moxeparvovec-Rokl Per Therapeutic Dose	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
J1426	Injection Casimersen 10 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J1427	Injection Viltolarsen 10 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J1428	Injection Eteplirsen 10 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J1429	Injection Golodirsen 10 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J1440	Fecal Microbiota Live - Jslm 1 Ml	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J1551	Injection Immune Globulin (Cutaquig) 100 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J1554	Injection Immune Globulin (Asceniv) 500 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_

J1562	Injection Immune Globulin (Vivaglobin) 100 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J1566	Injection Immune Globulin Intravenous Lyophilized (E. G. Powder) Not Otherwise Specified 500 Mg	Unlisted Procedure; May require Prior Authorization per contract agreement.	_	_	_
J1576	Injection Immune Globulin (Panzyga) Intravenous Non-Lyophilized (E.G. Liquid) 500 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J1599	Injection Immune Globulin Intravenous Non-Lyophilized (E.G. Liquid) Not Otherwise Specified 500 Mg	Unlisted Procedure; May require Prior Authorization per contract agreement.	_	_	_
J1620	Injection Gonadorelin Hydrochloride Per 100 Mcg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J1632	Injection Brexanolone 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J1675	Injection Histrelin Acetate 10 Micrograms	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J1726	Injection Hydroxyprogesterone Caproate (Makena) 10 Mg	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
J1729	Injection Hydroxyprogesterone Caproate Not Otherwise Specified 10 Mg	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
J1746	Injection Ibalizumab-Uiyk 10 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_

J1747	Injection Spesolimab-Sbzo 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J1811	Insulin (Fiasp) For Administration Through Dme (I.E. Insulin Pump) Per 50 Units	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J1812	Insulin (Fiasp) Per 5 Units	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J1813	Insulin (Lyumjev) For Administration Through Dme (I.E. Insulin Pump) Per 50 Units	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J1814	Insulin (Lyumjev) Per 5 Units	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J1823	Injection Inebilizumab-Cdon 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J1930	Injection Lanreotide 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	3/1/2024	_	Add effective 03/01/2024
J1932	Injection Lanreotide (Cipla) 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J1951	Injection Leuprolide Acetate For Depot Suspension (Fensolvi) 0.25 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

J1954	Injection Leuprolide Acetate For Depot Suspension (Cipla) 7.5 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J1961	Injection Lenacapavir 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	6/30/2024	Retire effective 06/30/2024
J2182	Injection Mepolizumab 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J2278	Injection Ziconotide 1 Microgram	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J2320	Injection Nandrolone Decanoate Up To 50 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J2327	Injection Risankizumab-Rzaa Intravenous 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/15/2024	_	Add effective 4/15/2024
J2329	Injection Ublituximab-Xiiy 1Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J2353	Injection Octreotide Depot Form For Intramuscular Injection 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	3/1/2024	_	Add effective 03/01/2024
J2354	Injection Octreotide Non-Depot Form For Subcutaneous Or Intravenous Injection 25 Mcg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	3/1/2024	_	Add effective 03/01/2024
J2356	Injection Tezepelumab-Ekko 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_

J2440	Injection Papaverine Hcl Up To 60 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J2502	Injection Pasireotide Long Acting 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J2508	Injection Pegunigalsidase Alfa-Iwxj 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
J2777	Injection Faricimab-Svoa 0.1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J2778	Injection Ranibizumab 0.1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J2779	Injection Ranibizumab Via Intravitreal Implant (Susvimo) 0.1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J2782	Injection Avacincaptad Pegol 0.1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2024	_	Add effective 4/1/2024
J2787	Riboflavin 5'-Phosphate Ophthalmic Solution Up To 3 Ml	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J2796	Injection Romiplostim 10 Micrograms	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	3/1/2024	_	Add effective 03/01/2024
J3032	Injection Eptinezumab-Jjmr 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_

J3055	Injection Talquetamab-Tgvs 0.25 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2024	_	Add effective 4/1/2024
J3111	Injection Romosozumab-Aqqg 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	3/1/2024	_	Add effective 03/01/2024
J3121	Injection Testosterone Enanthate 1Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J3145	Injection Testosterone Undecanoate 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J3241	Injection Teprotumumab-Trbw 10 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J3245	Injection Tildrakizumab 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J3285	Injection Treprostinil 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J3299	Injection Triamcinolone Acetonide (Xipere) 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J3355	Injection Urofollitropin 75 Iu	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_

J3380	Injection Vedolizumab Intravenous 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J3396	Injection Verteporfin 0.1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J3398	Injection Voretigene Neparvovec-Rzyl 1 Billion Vector Genomes	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J3399	Injection Onasemnogene Abeparvovec-Xioi Per Treatment Up To 5X10^15 Vector Genomes	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J3401	Beremagene Geperpavec-Svdt For Topical Administration Containing Nominal 5 X 10^9 Pfu/Ml Vector Genomes Per 0.1 Ml	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
J3490	Unclassified Drugs	Unlisted Procedure; May require Prior Authorization per contract agreement.	_	_	_
J3520	Edetate Disodium Per 150 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J3570	Laetrile Amygdalin Vitamin B17	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
J3590	Unclassified Biologics	Unlisted Procedure; May require Prior Authorization per contract agreement.	_	_	_
J3591	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	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

J7183	Injection Von Willebrand Factor Complex (Human) Wilate 1 I.U. Vwf:Rco	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
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.	_	_	_
J7213	Injection Coagulation Factor Ix (Recombinant) Ixinity 1 I.U.	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J7308	Aminolevulinic Acid Hcl For Topical Administration 20% Single Unit Dosage Form (354 Mg)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J7309	Methyl Aminolevulinate (Mal) For Topical Administration 16.8% 1 Gram	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J7311	Injection Fluocinolone Acetonide Intravitreal Implant (Retisert) 0.01 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J7312	Injection Dexamethasone Intravitreal Implant 0.1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J7313	Injection Fluocinolone Acetonide Intravitreal Implant (Iluvien) 0.01 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J7316	Injection Ocriplasmin 0.125 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

J7345	Aminolevulinic Acid Hcl For Topical Administration 10% Gel 10 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J7351	Injection Bimatoprost Intracameral Implant 1 Microgram	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J7402	Mometasone Furoate Sinus Implant (Sinuva) 10 Micrograms	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J7599	Immunosuppressive Drug 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).	_	_	_
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).	_	_	_
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).	_	_	_
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).	_	_	_
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).	_	_	_
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).	_	_	_
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).	_	_	_

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).	_	_	_
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).	_	_	_
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).	_	_	_
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).	_	_	_
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).	_	_	_
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).	_	_	_
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).	_	_	_
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).	_	_	_
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).	_	_	_
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).	_	_	_
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).	_	_	_

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).	_	_	_
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).	_	_	_
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).	_	_	_
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).	_	_	_
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).	_	_	_
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).	_	_	_
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).	_	_	_
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).	_	_	_
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).	_	_	_
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).	_	_	_
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).	_	_	_

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).	_	_	_
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).	_	_	_
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).	_	_	_
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).	_	_	_
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.	_	_	_
J9029	Intravesical Instillation Nadofaragene Firadenovec-Vncg Per Therapeutic Dose	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J9037	Injection Belantamab Mafodontin-Blmf 0.5 Mg	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	4/1/2024	_	Add effective 4/1/2024

J9056	Injection Bendamustine Hydrochloride (Vivimusta) 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J9057	Injection Copanlisib 1 Mg	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	4/1/2024	_	Add effective 4/1/2024
J9058	Injection Bendamustine Hydrochloride (Apotex) 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J9059	Injection Bendamustine Hydrochloride (Baxter) 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J9063	Injection Mirvetuximab Soravtansine-Gynx 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J9247	Injection Melphalan Flufenamide 1Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J9258	Injection Paclitaxel Protein-Bound Particles (Teva) Not Therapeutically Equivalent To J9264 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	6/30/2024	Add effective 01/01/2024 Retire effective 06/30/2024
J9259	Injection Paclitaxel Protein-Bound Particles (American Regent) Not Therapeutically Equivalent To J9264 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J9274	Injection Tebentafusp-Tebn 1 Microgram	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J9285	Injection Olaratumab 10 Mg	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
J9286	Injection Glofitamab-Gxbm 2.5 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024

J9313	Injection Moxetumomab Pasudotox-Tdfk 0.01 Mg	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	4/1/2024	_	Add effective 4/1/2024
J9321	Injection Epcoritamab-Bysp 0.16 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
J9331	Injection Sirolimus Protein-Bound Particles 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J9332	Injection Efgartigimod Alfa-Fcab 2Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J9333	Injection Rozanolixizumab-Noli 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
J9334	Injection Efgartigimod Alfa 2 Mg And Hyaluronidase-Qvfc	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
J9347	Injection Tremelimumab-Actl 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
J9350	Injection Mosunetuzumab-Axgb 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J9376	Injection Pozelimab-Bbfg 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2024	_	Add effective 4/1/2024
J9380	Injection Teclistamab-Cqyv 0.5 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_

J9381	Injection Teplizumab-Mzwv 5 Mcg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J9600	Injection Porfimer Sodium 75 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
J9999	Not Otherwise Classified Antineoplastic Drugs	Unlisted Procedure; May require Prior Authorization per contract agreement.	_	_	_
K0002	Standard Hemi (Low Seat) Wheelchair	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0003	Lightweight Wheelchair	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0004	High Strength Lightweight Wheelchair	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0005	Ultralightweight Wheelchair	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0006	Heavy Duty Wheelchair	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0007	Extra Heavy Duty Wheelchair	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0008	Custom Manual Wheelchair/Base	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

K0009	Other Manual Wheelchair/Base	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0010	Standard - Weight Frame Motorized/Power Wheelchair	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0011	Standard - Weight Frame Motorized/Power Wheelchair With Programmable Control Parameters For Speed Adjustment Tremor Dampening Acceleration Control And Braking	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0012	Lightweight Portable Motorized/Power Wheelchair	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0013	Custom Motorized/Power Wheelchair Base	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0014	Other Motorized/Power Wheelchair Base	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0053	Elevating Footrests Articulating (Telescoping) Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0056	Seat Height Less Than 17 Or Equal To Or Greater Than 21 For A High Strength Lightweight Or Ultralightweight Wheelchair	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0065	Spoke Protectors Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

K0108	Wheelchair Component Or Accessory Not Otherwise Specified	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
K0455	Infusion Pump Used For Uninterrupted Parenteral Administration Of Medication (E. G. Epoprostenol Or Treprostinol)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0669	Seat/Back Custom; No Dme Pdac Ver	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0743	Suction Pump Home Model Portable For Use On Wounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0744	Absorptive Wound Dressing For Use With Suction Pump Home Model Portable Pad Size 16 Square Inches Or Less	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0745	Absorptive Wound Dressing For Use With Suction Pump Home Model Portable Pad Size More Than 16 Square Inches But Less Than Or Equal To 48 Square Inches	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0746	Absorptive Wound Dressing For Use With Suction Pump Home Model Portable Pad Size Greater Than 48 Square Inches	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0800	Power Operated Vehicle Group 1 Standard Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

K0801	Power Operated Vehicle Group 1 Heavy Duty Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0802	Power Operated Vehicle Group 1 Very Heavy Duty Patient Weight Capacity 451 To 600 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0806	Power Operated Vehicle Group 2 Standard Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0807	Power Operated Vehicle Group 2 Heavy Duty Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0808	Power Operated Vehicle Group 2 Very Heavy Duty Patient Weight Capacity 451 To 600 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0812	Power Operated Vehicle Not Otherwise Classified	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
K0813	Power Wheelchair Group 1 Standard Portable Sling/Solid Seat And Back Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0814	Power Wheelchair Group 1 Standard Portable Captains Chair Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

K0815	Power Wheelchair Group 1 Standard Sling/Solid Seat And Back Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0816	Power Wheelchair Group 1 Standard Captains Chair Patient Weight Capactiy Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0820	Power Wheelchair Group 2 Standard Portable Sling/Solid Seat/Back Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0821	Power Wheelchair Group 2 Standard Portable Captains Chair Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0822	Power Wheelchair Group 2 Standard Sling/Solid Seat/Back Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0823	Power Wheelchair Group 2 Standard Captains Chair Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0824	Power Wheelchair Group 2 Heavy Duty Sling/Solid Seat/Back Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0825	Power Wheelchair Group 2 Heavy Duty Captains Chair Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0826	Power Wheelchair Group 2 Very Heavy Duty Sling/Solid Seat/Back Patient Weight Capacity 451 To 600 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

K0827	Power Wheelchair Group 2 Very Heavy Duty Captains Chair Patient Weight Capacity 451 To 600 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0828	Power Wheelchair Group 2 Extra Heavy Duty Sling/Solid Seat/Back Patient Weight Capacity 601 Pounds Or More	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0829	Power Wheelchair Group 2 Extra Heavy Duty Captains Chair Patient Weight Capacity 601 Pounds Or More	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0830	Power Wheelchair Group 2 Standard Seat Elevator Sling/Solid Seat/Back Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0831	Power Wheelchair Group 2 Standard Seat Elevator Captains Chair Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0835	Power Wheelchair Group 2 Standard Single Power Option Sling/Solid Seat/Back Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0836	Power Wheelchair Group 2 Standard Single Power Option Captains Chair Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0837	Power Wheelchair Group 2 Heavy Duty Single Power Option Sling/Solid Seat/Back Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0838	Power Wheelchair Group 2 Heavy Duty Single Power Option Captains Chair Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

K0839	Power Wheelchair Group 2 Very Heavy Duty Single Power Option Sling/Solid Seat/Back Patient Weight Capacity 451 To 600 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0840	Power Wheelchair Group 2 Extra Heavy Duty Single Power Option Sling/Solid Seat/Back Patient Weight Capacity 601 Pounds Or More	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0841	Power Wheelchair Group 2 Standard Multiple Power Option Sling/Solid Seat/Back Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0842	Power Wheelchair Group 2 Standard Multiple Power Option Captains Chair Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0843	Power Wheelchair Group 2 Heavy Duty Multiple Power Option Sling/Solid Seat/Back Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0848	Power Wheelchair Group 3 Standard Sling/Solid Seat/Back Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0849	Power Wheelchair Group 3 Standard Captains Chair Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0850	Power Wheelchair Group 3 Heavy Duty Sling/Solid Seat/Back Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0851	Power Wheelchair Group 3 Heavy Duty Captains Chair Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

K0852	Power Wheelchair Group 3 Very Heavy Duty Sling/Solid Seat/Back Patient Weight Capacity 451 To 600 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0853	Power Wheelchair Group 3 Very Heavy Duty Captains Chair Patient Weight Capacity 451 To 600 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0854	Power Wheelchair Group 3 Extra Heavy Duty Sling/Solid Seat/Back Patient Weight Capacity 601 Pounds Or More	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0855	Power Wheelchair Group 3 Extra Heavy Duty Captains Chair Patient Weight Capacity 601 Pounds Or More	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0856	Power Wheelchair Group 3 Standard Single Power Option Sling/Solid Seat/Back Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0857	Power Wheelchair Group 3 Standard Single Power Option Captains Chair Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0858	Power Wheelchair Group 3 Heavy Duty Single Power Option Sling/Solid Seat/Back Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0859	Power Wheelchair Group 3 Heavy Duty Single Power Option Captains Chair Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0860	Power Wheelchair Group 3 Very Heavy Duty Single Power Option Sling/Solid Seat/Back Patient Weight Capacity 451 To 600 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

K0861	Power Wheelchair Group 3 Standard Multiple Power Option Sling/Solid Seat/Back Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0862	Power Wheelchair Group 3 Heavy Duty Multiple Power Option Sling/Solid Seat/Back Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0863	Power Wheelchair Group 3 Very Heavy Duty Multiple Power Option Sling/Solid Seat/Back Patient Weight Capacity 451 To 600 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0864	Power Wheelchair Group 3 Extra Heavy Duty Multiple Power Option Sling/Solid Seat/Back Patient Weight Capacity 601 Pounds Or More	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0868	Power Wheelchair Group 4 Standard Sling/Solid Seat/Back Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0869	Power Wheelchair Group 4 Standard Captains Chair Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0870	Power Wheelchair Group 4 Heavy Duty Sling/Solid Seat/Back Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0871	Power Wheelchair Group 4 Very Heavy Duty Sling/Solid Seat/Back Patient Weight Capacity 451 To 600 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0877	Power Wheelchair Group 4 Standard Single Power Option Sling/Solid Seat/Back Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

K0878	Power Wheelchair Group 4 Standard Single Power Option Captains Chair Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0879	Power Wheelchair Group 4 Heavy Duty Single Power Option Sling/Solid Seat/Back Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0880	Power Wheelchair Group 4 Very Heavy Duty Single Power Option Sling/Solid Seat/Back Patient Weight 451 To 600 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0884	Power Wheelchair Group 4 Standard Multiple Power Option Sling/Solid Seat/Back Patient Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0885	Power Wheelchair Group 4 Standard Multiple Power Option Captains Chair Weight Capacity Up To And Including 300 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0886	Power Wheelchair Group 4 Heavy Duty Multiple Power Option Sling/Solid Seat/Back Patient Weight Capacity 301 To 450 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0890	Power Wheelchair Group 5 Pediatric Single Power Option Sling/Solid Seat/Back Patient Weight Capacity Up To And Including 125 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0891	Power Wheelchair Group 5 Pediatric Multiple Power Option Sling/Solid Seat/Back Patient Weight Capacity Up To And Including 125 Pounds	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K0898	Power Wheelchair Not Otherwise Classified	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_

K0899	Power Mobile Device; No Dme Pdac	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K1004	Low Frequency Ultrasonic Diathermy Treatment Device For Home Use	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
K1007	Bilateral Hip Knee Ankle Foot Device Powered Includes Pelvic Component Single Or Double Upright(S) Knee Joints Any Type With Or Without Ankle Joints Any Type Includes All Components And Accessories Motors Microprocessors Sensors	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
K1027	Oral Device/Appliance Used To Reduce Upper Airway Collapsibility Without Fixed Mechanical Hinge Custom Fabricated Includes Fitting And Adjustment	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K1030	External Recharging System For Battery (Internal) For Use With Implanted Cardiac Contractility Modulation Generator Replacement Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
K1034	Provision Of Covid-19 Test Nonprescription Self-Administered And Self-Collected Use Fda Approved Authorized Or Cleared One Test Count	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.	_	_	_
K1035	Molecular Diagnostic Test Reader Nonprescription Self-Administered And Self-Collected Use Fda Approved Authorized Or Cleared	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
K1036	Supplies And Accessories (E.G. Transducer) For Low Frequency Ultrasonic Diathermy Treatment Device Per Month	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
K1037	Docking Station For Use With Oral Device/Appliance Used To Reduce Upper Airway Collapsibility	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2024	_	Add effective 4/1/2024
L0120	Cervical Flexible Non-Adjustable Prefabricated Off-The-Shelf (Foam Collar)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L0999	Addition To Spinal Orthosis Not Otherwise Specified	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
L1320	Thoracic Pectus Carinatum Orthosis Sternal Compression Rigid Circumferential Frame With Anterior And Posterior Rigid Pads Custom Fabricated	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2024	_	Add effectuce 04/01/2024

L1499	Spinal Orthosis Not Otherwise Specified	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
L1834	Knee Orthosis Without Knee Joint Rigid Custom-Fabricated	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L1840	Knee Orthosis Derotation Medial-Lateral Anterior Cruciate Ligament Custom Fabricated	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L1844	Knee Orthosis Single Upright Thigh And Calf With Adjustable Flexion And Extension Joint (Unicentric Or Polycentric) Medial-Lateral And Rotation Control With Or Without Varus/Valgus Adjustment Custom Fabricated	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L1846	Knee Orthosis Double Upright Thigh And Calf With Adjustable Flexion And Extension Joint (Unicentric Or Polycentric) Medial-Lateral And Rotation Control With Or Without Varus/Valgus Adjustment Custom Fabricated	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L1860	Knee Orthosis Modification Of Supracondylar Prosthetic Socket Custom-Fabricated (Sk)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L2005	Knee Ankle Foot Orthosis Any Material Single Or Double Upright Stance Control Automatic Lock And Swing Phase Release Any Type Activation Includes Ankle Joint Any Type Custom Fabricated	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L2999	Lower Extremity Orthoses Not Otherwise Specified	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
L3001	Foot Insert Removable Molded To Patient Model Spenco Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3002	Foot Insert Removable Molded To Patient Model Plastazote Or Equal Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3003	Foot Insert Removable Molded To Patient Model Silicone Gel Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3010	Foot Insert Removable Molded To Patient Model Longitudinal Arch Support Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3020	Foot Insert Removable Molded To Patient Model Longitudinal/ Metatarsal Support Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_

L3030	Foot Insert Removable Formed To Patient Foot Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3031	Foot Insert/Plate Removable Addition To Lower Extremity Orthosis High Strength Lightweight Material All Hybrid Lamination/Prepreg Composite Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3040	Foot Arch Support Removable Premolded Longitudinal Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3050	Foot Arch Support Removable Premolded Metatarsal Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3060	Foot Arch Support Removable Premolded Longitudinal/ Metatarsal Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3070	Foot Arch Support Non-Removable Attached To Shoe Longitudinal Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3080	Foot Arch Support Non-Removable Attached To Shoe Metatarsal Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3090	Foot Arch Support Non-Removable Attached To Shoe Longitudinal/Metatarsal Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3100	Hallus-Valgus Night Dynamic Splint Prefabricated Off-The-Shelf	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3140	Foot Abduction Rotation Bar Including Shoes	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3150	Foot Abduction Rotatation Bar Without Shoes	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3160	Foot Adjustable Shoe-Styled Positioning Device	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3170	Foot Plastic Silicone Or Equal Heel Stabilizer Prafabricated Off-The-Shelf Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3201	Orthopedic Shoe Oxford With Supinator Or Pronator Infant	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3202	Orthopedic Shoe Oxford With Supinator Or Pronator Child	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3203	Orthopedic Shoe Oxford With Supinator Or Pronator Junior	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3204	Orthopedic Shoe Hightop With Supinator Or Pronator Infant	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3206	Orthopedic Shoe Hightop With Supinator Or Pronator Child	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3207	Orthopedic Shoe Hightop With Supinator Or Pronator Junior	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 Footwear Ladies Shoe Oxford Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_

L3216	Orthopedic Footwear Ladies Shoe Depth Inlay Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3217	Orthopedic Footwear Ladies Shoe Hightop Depth Inlay Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3219	Orthopedic Footwear Mens Shoe Oxford Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3221	Orthopedic Footwear Mens Shoe Depth Inlay Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3222	Orthopedic Footwear Mens Shoe Hightop Depth Inlay Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3224	Orthopedic Footwear Woman'S Shoe Oxford Used As An Integral Part Of A Brace (Orthosis)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3225	Orthopedic Footwear Man'S Shoe Oxford Used As An Integral Part Of A Brace (Orthosis)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3230	Orthopedic Footwear Custom Shoe Depth Inlay Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3250	Orthopedic Footwear Custom Molded Shoe Removable Inner Mold Prosthetic Shoe Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3251	Foot Shoe Molded To Patient Model Silicone Shoe Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3252	Foot Shoe Molded To Patient Model Plastazote (Or Similar) Custom Fabricated Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3253	Foot Molded Shoe Plastazote (Or Similar) Custom Fitted Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3254	Non-Standard Size Or Width	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3255	Non-Standard Size Or Length	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3257	Orthopedic Footwear Additional Charge For Split Size	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	Lift Elevation Heel Tapered To Metatarsals Per Inch	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3310	Lift Elevation Heel And Sole Neoprene Per Inch	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3320	Lift Elevation Heel And Sole Cork Per Inch	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3330	Lift Elevation Metal Extension (Skate)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3332	Lift Elevation Inside Shoe Tapered Up To One-Half Inch	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3334	Lift Elevation Heel Per Inch	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3340	Heel Wedge Sach	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_

L3350	Heel Wedge	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3360	Sole Wedge Outside Sole	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3370	Sole Wedge Between Sole	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3380	Clubfoot Wedge	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3390	Outflare Wedge	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3400	Metatarsal Bar Wedge Rocker	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3410	Metatarsal Bar Wedge Between Sole	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3420	Full Sole And Heel Wedge Between Sole	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3430	Heel Counter Plastic Reinforced	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3440	Heel Counter Leather Reinforced	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3450	Heel Sach Cushion Type	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3455	Heel New Leather Standard	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3460	Heel New Rubber Standard	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3465	Heel Thomas With Wedge	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3470	Heel Thomas Extended To Ball	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3480	Heel Pad And Depression For Spur	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3485	Heel Pad Removable For Spur	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3500	Orthopedic Shoe Addition Insole Leather	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3510	Orthopedic Shoe Addition Insole Rubber	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3520	Orthopedic Shoe Addition Insole Felt Covered With Leather	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_

L3530	Orthopedic Shoe Addition Sole Half	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3540	Orthopedic Shoe Addition Sole Full	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3550	Orthopedic Shoe Addition Toe Tap Standard	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3560	Orthopedic Shoe Addition Toe Tap Horseshoe	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3570	Orthopedic Shoe Addition Special Extension To Instep (Leather With Eyelets)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3580	Orthopedic Shoe Addition Convert Instep To Velcro Closure	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3590	Orthopedic Shoe Addition Convert Firm Shoe Counter To Soft Counter	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3595	Orthopedic Shoe Addition March Bar	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3600	Transfer Of An Orthosis From One Shoe To Another Caliper Plate Existing	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3610	Transfer Of An Orthosis From One Shoe To Another Caliper Plate New	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3620	Transfer Of An Orthosis From One Shoe To Another Solid Stirrup Existing	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3630	Transfer Of An Orthosis From One Shoe To Another Solid Stirrup New	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3640	Transfer Of An Orthosis From One Shoe To Another Dennis Browne Splint (Riveton) Both Shoes	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
L3649	Orthopedic Shoe Modification Addition Or Transfer Not Otherwise Specified	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review. Unlisted or Undefined	_	_	_
L3999	Upper Limb Orthosis Not Otherwise Specified	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
L5610	Addition To Lower Extremity Endoskeletal System Above Knee Hydracadence System	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5611	Addition To Lower Extremity Endoskeletal System Above Knee - Knee Disarticulation 4 Bar Linkage With Friction Swing Phase Control	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5613	Addition To Lower Extremity Endoskeletal System Above Knee-Knee Disarticulation 4 Bar Linkage With Hydraulic Swing Phase Control	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

L5614	Addition To Lower Extremity Exoskeletal System Above Knee-Knee Disarticulation 4 Bar Linkage With Pneumatic Swing Phase Control	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5615	Addition Endoskeletal Knee-Shin System 4 Bar Linkage Or Multiaxial Fluid Swing And Stance Phase Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
L5616	Addition To Lower Extremity Endoskeletal System Above Knee Universal Multiplex System Friction Swing Phase Control	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5620	Addition To Lower Extremity Test Socket Below Knee	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5624	Addition To Lower Extremity Test Socket Above Knee	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5629	Addition To Lower Extremity Below Knee Acrylic Socket	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5631	Addition To Lower Extremity Above Knee Or Knee Disarticulation Acrylic Socket	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5638	Addition To Lower Extremity Below Knee Leather Socket	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5639	Addition To Lower Extremity Below Knee Wood Socket	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

L5640	Addition To Lower Extremity Knee Disarticulation Leather Socket	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5642	Addition To Lower Extremity Above Knee Leather Socket	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5644	Addition To Lower Extremity Above Knee Wood Socket	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5645	Addition To Lower Extremity Below Knee Flexible Inner Socket External Frame	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5646	Addition To Lower Extremity Below Knee Air Fluid Gel Or Equal Cushion Socket	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5647	Addition To Lower Extremity Below Knee Suction Socket	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5648	Addition To Lower Extremity Above Knee Air Fluid Gel Or Equal Cushion Socket	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5651	Addition To Lower Extremity Above Knee Flexible Inner Socket External Frame	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5652	Addition To Lower Extremity Suction Suspension Above Knee Or Knee Disarticulation Socket	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

L5670	Addition To Lower Extremity Below Knee Molded Supracondylar Suspension ('Pts' Or Similar)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5676	Additions To Lower Extremity Below Knee Knee Joints Single Axis Pair	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5704	Custom Shaped Protective Cover Below Knee	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5705	Custom Shaped Protective Cover Above Knee	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5706	Custom Shaped Protective Cover Knee Disarticulation	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5710	Addition Exoskeletal Knee-Shin System Single Axis Manual Lock	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5711	Additions Exoskeletal Knee-Shin System Single Axis Manual Lock Ultra-Light Material	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5712	Addition Exoskeletal Knee-Shin System Single Axis Friction Swing And Stance Phase Control (Safety Knee)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5714	Addition Exoskeletal Knee-Shin System Single Axis Variable Friction Swing Phase Control	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

L5716	Addition Exoskeletal Knee-Shin System Polycentric Mechanical Stance Phase Lock	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5718	Addition Exoskeletal Knee-Shin System Polycentric Friction Swing And Stance Phase Control	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5722	Addition Exoskeletal Knee-Shin System Single Axis Pneumatic Swing Friction Stance Phase Control	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5724	Addition Exoskeletal Knee-Shin System Single Axis Fluid Swing Phase Control	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5726	Addition Exoskeletal Knee-Shin System Single Axis External Joints Fluid Swing Phase Control	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5728	Addition Exoskeletal Knee-Shin System Single Axis Fluid Swing And Stance Phase Control	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5780	Addition Exoskeletal Knee-Shin System Single Axis Pneumatic/Hydra Pneumatic Swing Phase Control	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5785	Addition Exoskeletal System Below Knee Ultra-Light Material (Titanium Carbon Fiber Or Equal)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5790	Addition Exoskeletal System Above Knee Ultra-Light Material (Titanium Carbon Fiber Or Equal)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

L5795	Addition Exoskeletal System Hip Disarticulation Ultra-Light Material (Titanium Carbon Fiber Or Equal)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5810	Addition Endoskeletal Knee-Shin System Single Axis Manual Lock	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5811	Addition Endoskeletal Knee-Shin System Single Axis Manual Lock Ultra-Light Material	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5812	Addition Endoskeletal Knee-Shin System Single Axis Friction Swing And Stance Phase Control (Safety Knee)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5814	Addition Endoskeletal Knee-Shin System Polycentric Hydraulic Swing Phase Control Mechanical Stance Phase Lock	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5816	Addition Endoskeletal Knee-Shin System Polycentric Mechanical Stance Phase Lock	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5818	Addition Endoskeletal Knee-Shin System Polycentric Friction Swing And Stance Phase Control	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5822	Addition Endoskeletal Knee-Shin System Single Axis Pneumatic Swing Friction Stance Phase Control	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5824	Addition Endoskeletal Knee-Shin System Single Axis Fluid Swing Phase Control	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

L5826	Addition Endoskeletal Knee-Shin System Single Axis Hydraulic Swing Phase Control With Miniature High Activity Frame	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5828	Addition Endoskeletal Knee-Shin System Single Axis Fluid Swing And Stance Phase Control	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5830	Addition Endoskeletal Knee-Shin System Single Axis Pneumatic/ Swing Phase Control	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5840	Addition Endoskeletal Knee/Shin System 4-Bar Linkage Or Multiaxial Pneumatic Swing Phase Control	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5841	Addition Endoskeletal Knee-Shin System Polycentric Pneumatic Swing And Stance Phase Control	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2024	_	Add effectuce 04/01/2024
L5848	Addition To Endoskeletal Knee-Shin System Fluid Stance Extension Dampening Feature With Or Without Adjustability	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5856	Addition To Lower Extremity Prosthesis Endoskeletal Knee-Shin System Microprocessor Control Feature Swing And Stance Phase Includes Electronic Sensor(S) Any Type	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5857	Addition To Lower Extremity Prosthesis Endoskeletal Knee-Shin System Microprocessor Control Feature Swing Phase Only Includes Electronic Sensor(S) Any Type	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5858	Addition To Lower Extremity Prosthesis Endoskeletal Knee Shin System Microprocessor Control Feature Stance Phase Only Includes Electronic Sensor(S) Any Type	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

L5859	Addition To Lower Extremity Prosthesis Endoskeletal Knee-Shin System Powered And Programmable Flexion/Extension Assist Control Includes Any Type Motor(S)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5926	Addition To Lower Extremity Prosthesis Endoskeletal Knee Disarticulation Above Knee Hip Disarticulation Positional Rotation Unit Any Type	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
L5961	Addition Endoskeletal System Polycentric Hip Joint Pneumatic Or Hydraulic Control Rotation Control With Or Without Flexion And/Or Extension Control	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5962	Addition Endoskeletal System Below Knee Flexible Protective Outer Surface Covering System	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5964	Addition Endoskeletal System Above Knee Flexible Protective Outer Surface Covering System	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5966	Addition Endoskeletal System Hip Disarticulation Flexible Protective Outer Surface Covering System	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5968	Addition To Lower Limb Prosthesis Multiaxial Ankle With Swing Phase Active Dorsiflexion Feature	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5969	Addition Endoskeletal Ankle-Foot Or Ankle System Power Assist Includes Any Type Motor(S)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5970	All Lower Extremity Prostheses Foot External Keel Sach Foot	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

L5972	All Lower Extremity Prostheses Foot Flexible Keel	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5973	Endoskeletal Ankle Foot System Microprocessor Controlled Feature Dorsiflexion And/Or Plantar Flexion Control Includes Power Source	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5974	All Lower Extremity Prostheses Foot Single Axis Ankle/Foot	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5976	All Lower Extremity Prostheses Energy Storing Foot (Seattle Carbon Copy Ii Or Equal)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5978	All Lower Extremity Prostheses Foot Multiaxial Ankle/Foot	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5979	All Lower Extremity Prosthesis Multi-Axial Ankle Dynamic Response Foot One Piece System	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5980	All Lower Extremity Prostheses Flex Foot System	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5981	All Lower Extremity Prostheses Flex-Walk System Or Equal	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5982	All Exoskeletal Lower Extremity Prostheses Axial Rotation Unit	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

L5984	All Endoskeletal Lower Extremity Prosthesis Axial Rotation Unit With Or Without Adjustability	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5985	All Endoskeletal Lower Extremity Prostheses Dynamic Prosthetic Pylon	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5986	All Lower Extremity Prostheses Multi-Axial Rotation Unit ('Mcp' Or Equal)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5987	All Lower Extremity Prosthesis Shank Foot System With Vertical Loading Pylon	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L5991	Addition To Lower Extremity Prostheses Osseointegrated External Prosthetic Connector	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
L5999	Lower Extremity Prosthesis Not Otherwise Specified	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
L6026	Transcarpal/Metacarpal Or Partial Hand Disarticulation Prosthesis External Power Self-Suspended Inner Socket With Removable Forearm Section Electrodes And Cables Two Batteries Charger Myoelectric Control Of Terminal Device Excludes Terminal Device(S)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L6611	Addition To Upper Extremity Prosthesis External Powered Additional Switch Any Type	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L6621	Upper Extremity Prosthesis Addition Flexion/Extension Wrist With Or Without Friction For Use With External Powered Terminal Device	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L6715	Terminal Device Multiple Articulating Digit Includes Motor(S) Initial Issue Or Replacement	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

L6880	Electric Hand Switch Or Myolelectric Controlled Independently Articulating Digits Any Grasp Pattern Or Combination Of Grasp Patterns Includes Motor(S)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L6882	Microprocessor Control Feature Addition To Upper Limb Prosthetic Terminal Device	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L6920	Wrist Disarticulation External Power Self-Suspended Inner Socket Removable Forearm Shell Otto Bock Or Equal Switch Cables Two Batteries And One Charger Switch Control Of Terminal Device	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L6925	Wrist Disarticulation External Power Self-Suspended Inner Socket Removable Forearm Shell Otto Bock Or Equal Electrodes Cables Two Batteries And One Charger Myoelectronic Control Of Terminal Device	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L6930	Below Elbow External Power Self-Suspended Inner Socket Removable Forearm Shell Otto Bock Or Equal Switch Cables Two Batteries And One Charger Switch Control Of Terminal Device	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L6935	Below Elbow External Power Self-Suspended Inner Socket Removable Forearm Shell Otto Bock Or Equal Electrodes Cables Two Batteries And One Charger Myoelectronic Control Of Terminal Device	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L6940	Elbow Disarticulation External Power Molded Inner Socket Removable Humeral Shell Outside Locking Hinges Forearm Otto Bock Or Equal Switch Cables Two Batteries And One Charger Switch Control Of Terminal Device	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L6945	Elbow Disarticulation External Power Molded Inner Socket Removable Humeral Shell Outside Locking Hinges Forearm Otto Bock Or Equal Electrodes Cables Two Batteries And One Charger Myoelectronic Control Of Terminal Device	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L6950	Above Elbow External Power Molded Inner Socket Removable Humeral Shell Internal Locking Elbow Forearm Otto Bock Or Equal Switch Cables Two Batteries And One Charger Switch Control Of Terminal Device	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

L6955	Above Elbow External Power Molded Inner Socket Removable Humeral Shell Internal Locking Elbow Forearm Otto Bock Or Equal Electrodes Cables Two Batteries And One Charger Myoelectronic Control Of Terminal Device	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L6960	Shoulder Disarticulation External Power Molded Inner Socket Removable Shoulder Shell Shoulder Bulkhead Humeral Section Mechanical Elbow Forearm Otto Bock Or Equal Switch Cables Two Batteries And One Charger Switch Control Of Terminal Device	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L6965	Shoulder Disarticulation External Power Molded Inner Socket Removable Shoulder Shell Shoulder Bulkhead Humeral Section Mechanical Elbow Forearm Otto Bock Or Equal Electrodes Cables Two Batteries And One Charger Myoelectronic Control Of Terminal Device	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L6970	Interscapular-Thoracic External Power Molded Inner Socket Removable Shoulder Shell Shoulder Bulkhead Humeral Section Mechanical Elbow Forearm Otto Bock Or Equal Switch Cables Two Batteries And One Charger Switch Control Of Terminal Device	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L6975	Interscapular-Thoracic External Power Molded Inner Socket Removable Shoulder Shell Shoulder Bulkhead Humeral Section Mechanical Elbow Forearm Otto Bock Or Equal Electrodes Cables Two Batteries And One Charger Myoelectronic Control Of Terminal Device	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L7007	Electric Hand Switch Or Myoelectric Controlled Adult	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L7008	Electric Hand Switch Or Myoelectric Controlled Pediatric	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L7009	Electric Hook Switch Or Myoelectric Controlled Adult	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L7040	Prehensile Actuator Switch Controlled	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

L7045	Electric Hook Switch Or Myoelectric Ontrolled Pediatric	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L7170	Electronic Elbow Hosmer Or Equal Switch Controlled	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L7180	Electronic Elbow Microprocessor Sequential Control Of Elbow And Terminal Device	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L7181	Electronic Elbow Microprocessor Simultaneous Control Of Elbow And Terminal Device	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L7185	Electronic Elbow Adolescent Variety Village Or Equal Switch Controlled	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L7186	Electronic Elbow Child Variety Village Or Equal Switch Controlled	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L7190	Electronic Elbow Adolescent Variety Village Or Equal Myoelectronically Controlled	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L7191	Electronic Elbow Child Variety Village Or Equal Myoelectronically Controlled	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L7259	Electronic Wrist Rotator Any Type	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

L7360	Six Volt Battery Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L7362	Battery Charger Six Volt Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L7364	Twelve Volt Battery Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L7366	Battery Charger Twelve Volt Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L7367	Lithium Ion Battery Rechargeable Replacement	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L7368	Lithium Ion Battery Charger Replacement Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L7499	Upper Extremity Prosthesis Not Otherwise Specified	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	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L7902	Tension Ring For Vacuum Erection Device Any Type Replacement Only Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L8039	Breast Prosthesis Not Otherwise Specified	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_

L8048	Unspecified Maxillofacial Prosthesis By Report Provided By A Non-Physician	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
L8499	Unlisted Procedure For Miscellaneous Prosthetic Services	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
L8603	Injectable Bulking Agent Collagen Implant Urinary Tract 2. 5 Ml Syringe Includes Shipping And Necessary Supplies	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	5/15/2024	_	Add effective 05/15/2024
L8604	Injectable Bulking Agent Dextranomer/Hyaluronic Acid Copolymer Implant Urinary Tract 1 Ml Includes Shipping And Necessary Supplies	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L8605	Injectable Bulking Agent Dextranomer/Hyaluronic Acid Copolymer Implant Anal Canal 1 Ml Includes Shipping And Necessary Supplies	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
L8606	Injectable Bulking Agent Synthetic Implant Urinary Tract 1 Ml Syringe Includes Shipping And Necessary Supplies	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L8607	Injectable Bulking Agent For Vocal Cord Medialization 0.1 Ml Includes Shipping And Necessary Supplies	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L8608	Miscellaneous External Component Supply Or Accessory For Use With The Argus Ii Retinal Prosthesis 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).	_	_	_
L8609	Artificial Cornea	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L8612	Aqueous Shunt	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L8678	Electrical Stimulator Supplies (External) For Use With Implantable Neurostimulator Per Month	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

L8679	Implantable Neurostimulator Pulse Generator Any Type	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L8680	Implantable Neurostimulator Electrode Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L8681	Patient Programmer (External) For Use With Implantable Programmable Neurostimulator Pulse Generator Replacement Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L8682	Implantable Neurostimulator Radiofrequency Receiver	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L8683	Radiofrequency Transmitter (External) For Use With Implantable Neurostimulator Radiofrequency Receiver	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L8685	Implantable Neurostimulator Pulse Generator Single Array Rechargeable Includes Extension	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L8686	Implantable Neurostimulator Pulse Generator Single Array Non-Rechargeable Includes Extension	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L8687	Implantable Neurostimulator Pulse Generator Dual Array Rechargeable Includes Extension	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L8688	Implantable Neurostimulator Pulse Generator Dual Array Non-Rechargeable Includes Extension	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

L8689	External Recharging System For Battery (Internal) For Use With Implantable Neurostimulator Replacement Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L8694	Auditory Osseointegrated Device Transducer/Actuator Replacement Only Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L8695	External Recharging System For Battery (External) For Use With Implantable Neurostimulator Replacement Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L8698	Miscellaneous Component Supply Or Accessory For Use With Total Artificial Heart System	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L8699	Prosthetic Implant Not Otherwise Specified	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
L8701	Powered Upper Extremity Range Of Motion Assist Device Elbow Wrist Hand With Single Or Double Upright(S) Includes Microprocessor Sensors All Components And Accessories Custom Fabricated	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
L8702	Powered Upper Extremity Range Of Motion Assist Device Elbow Wrist Hand Finger Single Or Double Upright(S) Includes Microprocessor Sensors All Components And Accessories Custom Fabricated	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
M0001	Advancing Cancer Care Mips Value Pathways	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M0002	Optimal Care For Kidney Health Mips Value Pathways	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M0003	Optimal Care For Patients With Episodic Neurological Conditions Mips Value Pathways	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M0004	Supportive Care For Neurodegenerative Conditions Mips Value Pathways	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M0005	Value In Primary Care Mips Value Pathway	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M0075	Cellular Therapy	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_

M0076	Prolotherapy	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
M0100	Intragastric Hypothermia Using Gastric Freezing	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M0240	Intravenous Infusion Or Subcutaneous Injection Casirivimab And Imdevimab Includes Infusion Or Injection And Post Administration Monitoring Subsequent Repeat Doses	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
M0241	Intravenous Infusion Or Subcutaneous Injection Casirivimab And Imdevimab Includes Infusion Or Injection And Post Administration Monitoring In The Home Or Residence This Includes A Beneficiary'S Home That Has Been Made Provider-Based To The Hospital During The Covid-19 Public Health Emergency Subsequent Repeat Doses	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
M0243	Intravenous Infusion Or Subcutaneous Injection Casirivimab And Imdevimab Includes Infusion Or Injection And Post Administration 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).	_	_	_
M0244	Intravenous Infusion Or Subcutaneous Injection Casirivimab And Imdevimab Includes Infusion Or Injection And Post Administration Monitoring In The Home Or Residence; This Includes A Beneficiary'S Home That Has Been Made Provider-Based To The Hospital During The Covid-19 Public Health Emergency	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
M0245	Intravenous Infusion Bamlanivimab And Etesevimab Includes Infusion And Post Administration 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).	_	_	_
M0246	Intravenous Infusion Bamlanivimab And Etesevimab Includes Infusion And Post Administration Monitoring In The Home Or Residence; This Includes A Beneficiary'S Home That Has Been Made Provider Based To The Hospital During The Covid 19 Public Health Emergency	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
M0300	Iv Chelation Therapy (Chemical Endarterectomy)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
M1150	Left Ventricular Ejection Fraction (Lvef) Less Than Or Equal To 40% Or Documentation Of Moderately Or Severely Depressed Left Ventricular Systolic Function	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1151	Patients With A History Of Heart Transplant Or With A Left Ventricular Assist Device (Lvad)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_

M1152	Patients With A History Of Heart Transplant Or With A Left Ventricular Assist Device (Lvad)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1153	Patient With Diagnosis Of Osteoporosis On Date Of Encounter	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1154	Hospice Services Provided To Patient Any Time During The Measurement Period	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1155	Patient Had Anaphylaxis Due To The Pneumococcal Vaccine Any Time During Or Before The Measurement Period	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1159	Hospice Services Provided To Patient Any Time During The Measurement Period	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1160	Patient Had Anaphylaxis Due To The Meningococcal Vaccine Any Time On Or Before The Patient'S 13Th Birthday	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1161	Patient Had Anaphylaxis Due To The Tetanus Diphtheria Or Pertussis Vaccine Any Time On Or Before The Patient'S 13Th Birthday	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1162	Patient Had Encephalitis Due To The Tetanus Diphtheria Or Pertussis Vaccine Any Time On Or Before The Patient'S 13Th Birthday	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1163	Patient Had Anaphylaxis Due To The Hpv Vaccine Any Time On Or Before The Patient'S 13Th Birthday	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1164	Patients With Dementia Any Time During The Patient'S History Through The End Of The Measurement Period	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1165	Patients Who Use Hospice Services Any Time During The Measurement Period	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1166	Pathology Report For Tissue Specimens Produced From Wide Local Excisions Or Re-Excisions	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1167	In Hospice Or Using Hospice Services During The Measurement Period	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1168	Patient Received An Influenza Vaccine On Or Between July 1 Of The Year Prior To The Measurement Period And June 30 Of The Measurement Period	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1169	Documentation Of Medical Reason(S) For Not Administering Influenza Vaccine (E.G. Prior Anaphylaxis Due To The Influenza Vaccine)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1170	Patient Did Not Receive An Influenza Vaccine On Or Between July 1 Of The Year Prior To The Measurement Period And June 30 Of The Measurement Period	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1171	Patient Received At Least One Td Vaccine Or One Tdap Vaccine Between Nine Years Prior To The Encounter And The End Of The Measurement Period	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1172	Documentation Of Medical Reason(S) For Not Administering Td Or Tdap Vaccine (E.G. Prior Anaphylaxis Due To The Td Or Tdap Vaccine Or History Of Encephalopathy Within Seven Days After A Previous Dose Of A Td-Containing Vaccine)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_

M1173	Patient Did Not Receive At Least One Td Vaccine Or One Tdap Vaccine Between Nine Years Prior To The Encounter And The End Of The Measurement Period	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1174	Patient Received At Least Two Doses Of The Herpes Zoster Recombinant Vaccine (At Least 28 Days Apart) Anytime On Or After The Patient'S 50Th Birthday Before Or During The Measurement Period	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1175	Documentation Of Medical Reason(S) For Not Administering Zoster Vaccine (E.G. Prior Anaphylaxis Due To The Zoster Vaccine)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1176	Patient Did Not Receive At Least Two Doses Of The Herpes Zoster Recombinant Vaccine (At Least 28 Days Apart) Anytime On Or After The Patient'S 50Th Birthday Before Or During The Measurement Period	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1177	Patient Received Any Pneumococcal Conjugate Or Polysaccharide Vaccine On Or After Their 60Th Birthday And Before The End Of The Measurement Period	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1178	Documentation Of Medical Reason(S) For Not Administering Pneumococcal Vaccine (E.G. Prior Anaphylaxis Due To The Pneumococcal Vaccine)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1179	Patient Did Not Receive Any Pneumococcal Conjugate Or Polysaccharide Vaccine On Or After Their 60Th Birthday And Before Or During Measurement Period	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1180	Patients On Immune Checkpoint Inhibitor Therapy	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1181	Grade 2 Or Above Diarrhea And/Or Grade 2 Or Above Colitis	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1182	Patients Not Eligible Due To Pre-Existing Inflammatory Bowel Disease (Ibd) (E.G. Ulcerative Colitis Crohn'S Disease)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1183	Documentation Of Immune Checkpoint Inhibitor Therapy Held And Corticosteroids Or Immunosuppressants Prescribed Or Administered	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1184	Documentation Of Medical Reason(S) For Not Prescribing Or Administering Corticosteroid Or Immunosuppressant Treatment (E.G. Allergy Intolerance Infectious Etiology Pancreatic Insufficiency Hyperthyroidism Prior Bowel Surgical Interventions Celiac Disease Receiving Other Medication Awaiting Diagnostic Workup Results For Alternative Etiologies Other Medical Reasons/Contraindication)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1185	Documentation Of Immune Checkpoint Inhibitor Therapy Not Held And/Or Corticosteroids Or Immunosuppressants Prescribed Or Administered Was Not Performed Reason Not Given	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1186	Patients Who Have An Order For Or Are Receiving Hospice Or Palliative Care	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_

M1187	Patients With A Diagnosis Of End Stage Renal Disease (Esrd)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1188	Patients With A Diagnosis Of Chronic Kidney Disease (Ckd) Stage 5	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1189	Documentation Of A Kidney Health Evaluation Defined By An Estimated Glomerular Filtration Rate (Egfr) And Urine Albumin-Creatinine Ratio (Uacr) Performed	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1190	Documentation Of A Kidney Health Evaluation Was Not Performed Or Defined By An Estimated Glomerular Filtration Rate (Egfr) And Urine Albumin-Creatinine Ratio (Uacr)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1191	Hospice Services Provided To Patient Any Time During The Measurement Period	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1192	Patients With An Existing Diagnosis Of Squamous Cell Carcinoma Of The Esophagus	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1193	Surgical Pathology Reports That Contain Impression Or Conclusion Of Or Recommendation For Testing Of Mmr By Immunohistochemistry Msi By Dna-Based Testing Status Or Both	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1194	Documentation Of Medical Reason(S) Surgical Pathology Reports Did Not Contain Impression Or Conclusion Of Or Recommendation For Testing Of Mmr By Immunohistochemistry Msi By Dna-Based Testing Status Or Both Tests Were Not Included (E.G. Patient Will Not Be Treated With Checkpoint Inhibitor Therapy No Residual Carcinoma Is Present In The Sample [Tissue Exhausted Or Status Post Neoadjuvant Treatment] Insufficient Tumor For Testing)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1195	Surgical Pathology Reports That Do Not Contain Impression Or Conclusion Of Or Recommendation For Testing Of Mmr By Immunohistochemistry Msi By Dna-Based Testing Status Or Both Reason Not Given	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1196	Initial (Index Visit) Numeric Rating Scale (Nrs) Visual Rating Scale (Vrs) Or Itchyquant Assessment Score Of Greater Than Or Equal To 4	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1197	Itch Severity Assessment Score Is Reduced By 3 Or More Points From The Initial (Index) Assessment Score To The Follow-Up Visit Score	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1198	Itch Severity Assessment Score Was Not Reduced By At Least 3 Points From Initial (Index) Score To The Follow-Up Visit Score Or Assessment Was Not Completed During The Follow-Up Encounter	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1199	Patients Receiving Rrt	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1200	Ace Inhibitor (Ace-I) Or Arb Therapy Prescribed During The Measurement Period	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_

M1201	Documentation Of Medical Reason(S) For Not Prescribing Ace Inhibitor (Ace-I) Or Arb Therapy During The Measurement Period (E.G. Pregnancy History Of Angioedema To Ace-I Other Allergy To Ace-I And Arb Hyperkalemia Or History Of Hyperkalemia While On Ace-I Or Arb Therapy Acute Kidney Injury Due To Ace-I Or Arb Therapy) Other Medical Reasons)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1202	Documentation Of Patient Reason(S) For Not Prescribing Ace Inhibitor Or Arb Therapy During The Measurement Period (E.G. Patient Declined Other Patient Reasons)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1203	Ace Inhibitor Or Arb Therapy Not Prescribed During The Measurement Period Reason Not Given	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1204	Initial (Index Visit) Numeric Rating Scale (Nrs) Visual Rating Scale (Vrs) Or Itchyquant Assessment Score Of Greater Than Or Equal To 4	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1205	Itch Severity Assessment Score Is Reduced By 3 Or More Points From The Initial (Index) Assessment Score To The Follow-Up Visit Score	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1206	Itch Severity Assessment Score Was Not Reduced By At Least 3 Points From Initial (Index) Score To The Follow-Up Visit Score Or Assessment Was Not Completed During The Follow-Up Encounter	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1207	Patient Is Screened For Food Insecurity Housing Instability Transportation Needs Utility Difficulties And Interpersonal Safety	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1208	Patient Is Not Screened For Food Insecurity Housing Instability Transportation Needs Utility Difficulties And Interpersonal Safety	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1209	At Least Two Orders For High-Risk Medications From The Same Drug Class (Table 4) Without Appropriate Diagnoses	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1210	At Least Two Orders For High-Risk Medications From The Same Drug Class (Table 4) Not Ordered	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
M1211	Most Recent Hemoglobin A1C Level > 9.0%	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1212	Hemoglobin A1C Level Is Missing Or Was Not Performed During The Measurement Period (12 Months)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1213	No History Of Spirometry Results With Confirmed Airflow Obstruction (Fev1/Fvc < 70%) And Present Spirometry Is >= 70%	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1214	Spirometry Results With Confirmed Airflow Obstruction (Fev1/Fvc < 70%) Documented And Reviewed	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1215	Documentation Of Medical Reason(S) For Not Documenting And Reviewing Spirometry Results (E.G. Patients With Dementia Or Tracheostomy)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024

M1216	No Spirometry Results With Confirmed Airflow Obstruction (Fev1/Fvc < 70%) Documented And/Or No Spirometry Performed With Results Documented During The Encounter	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1217	Documentation Of System Reason(S) For Not Documenting And Reviewing Spirometry Results (E.G. Spirometry Equipment Not Available At The Time Of The Encounter)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1218	Patient Has Copd Symptoms (E.G. Dyspnea Cough/Sputum Wheezing)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1219	Anaphylaxis Due To The Vaccine On Or Before The Date Of The Encounter	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1220	Dilated Retinal Eye Exam With Interpretation By An Ophthalmologist Or Optometrist Or Artificial Intelligence (Ai) Interpretation Documented And Reviewed; With Evidence Of Retinopathy	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1221	Dilated Retinal Eye Exam With Interpretation By An Ophthalmologist Or Optometrist Or Artificial Intelligence (Ai) Interpretation Documented And Reviewed; Without Evidence Of Retinopathy	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1222	Glaucoma Plan Of Care Not Documented Reason Not Otherwise Specified	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1223	Glaucoma Plan Of Care Documented	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1224	Intraocular Pressure (Iop) Reduced By A Value Less Than 20% From The Pre-Intervention Level	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1225	Intraocular Pressure (Iop) Reduced By A Value Of Greater Than Or Equal To 20% From The Pre-Intervention Level	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1226	Iop Measurement Not Documented Reason Not Otherwise Specified	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1227	Evidence-Based Therapy Was Prescribed	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1228	Patient Who Has A Reactive Hcv Antibody Test And Has A Follow Up Hcv Viral Test That Detected Hcv Viremia Has Hcv Treatment Initiated Within 3 Months Of The Reactive Hcv Antibody Test	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1229	Patient Who Has A Reactive Hcv Antibody Test And Has A Follow Up Hcv Viral Test That Detected Hcv Viremia Is Referred Within 1 Month Of The Reactive Hcv Antibody Test To A Clinician Who Treats Hcv Infection	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024

M1230	Patient Has A Reactive Hcv Antibody Test And Does Not Have A Follow Up Hcv Viral Test Or Patient Has A Reactive Hcv Antibody Test And Has A Follow Up Hcv Viral Test That Detects Hcv Viremia And Is Not Referred To A Clinician Who Treats Hcv Infection Within 1 Month And Does Not Have Hcv Treatment Initiated Within 3 Months Of The Reactive Hcv Antibody Test Reason Not Given	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1231	Patient Receives Hcv Antibody Test With Nonreactive Result	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1232	Patient Receives Hcv Antibody Test With Reactive Result	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1233	Patient Does Not Receive Hcv Antibody Test Or Patient Does Receive Hcv Antibody Test But Results Not Documented Reason Not Given	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1234	Patient Has A Reactive Hcv Antibody Test And Has A Follow Up Hcv Viral Test That Does Not Detect Hcv Viremia	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1235	Documentation Or Patient Report Of Hcv Antibody Test Or Hcv Rna Test Which Occurred Prior To The Performance Period	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1236	Baseline Mrs > 2	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1237	Patient Reason For Not Screening For Food Insecurity Housing Instability Transportation Needs Utility Difficulties And Interpersonal Safety (E.G. Patient Declined Or Other Patient Reasons)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1238	Documentation That Administration Of Second Recombinant Zoster Vaccine Could Not Occur During The Performance Period Due To The Recommended 2-6 Month Interval Between Doses (I.E First Dose Received After October 31)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1239	Patient Did Not Respond To The Question Of Patient Felt Heard And Understood By This Provider And Team	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1240	Patient Did Not Respond To The Question Of Patient Felt This Provider And Team Put My Best Interests First When Making Recommendations About My Care	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1241	Patient Did Not Respond To The Question Of Patient Felt This Provider And Team Saw Me As A Person Not Just Someone With A Medical Problem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1242	Patient Did Not Respond To The Question Of Patient Felt This Provider And Team Understood What Is Important To Me In My Life	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1243	Patient Provided A Response Other Than Completely True For The Question Of Patient Felt Heard And Understood By This Provider And Team	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024

M1244	Patient Provided A Response Other Than Completely True For The Question Of Patient Felt This Provider And Team Put My Best Interests First When Making Recommendations About My Care	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1245	Patient Provided A Response Other Than Completely True For The Question Of Patient Felt This Provider And Team Saw Me As A Person Not Just Someone With A Medical Problem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1246	Patient Provided A Response Other Than Completely True For The Question Of Patient Felt This Provider And Team Understood What Is Important To Me In My Life	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1247	Patient Responded Completely True For The Question Of Patient Felt This Provider And Team Put My Best Interests First When Making Recommendations About My Care	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1248	Patient Responded Completely True For The Question Of Patient Felt This Provider And Team Saw Me As A Person Not Just Someone With A Medical Problem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1249	Patient Responded Completely True For The Question Of Patient Felt This Provider And Team Understood What Is Important To Me In My Life	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1250	Patient Responded As Completely True For The Question Of Patient Felt Heard And Understood By This Provider And Team	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1251	Patients For Whom A Proxy Completed The Entire Hu Survey On Their Behalf For Any Reason (No Patient Involvement)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1252	Patients Who Did Not Complete At Least One Of The Four Patient Experience Hu Survey Items And Return The Hu Survey Within 60 Days Of The Ambulatory Palliative Care Visit	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1253	Patients Who Respond On The Patient Experience Hu Survey That They Did Not Receive Care By The Listed Ambulatory Palliative Care Provider In The Last 60 Days (Disavowal)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1254	Patients Who Were Deceased When The Hu Survey Reached Them	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1255	Patients Who Have Another Reason For Visiting The Clinic [Not Prenatal Or Postpartum Care] And Have A Positive Pregnancy Test But Have Not Established The Clinic As An Ob Provider (E.G. Plan To Terminate The Pregnancy Or Seek Prenatal Services Elsewhere)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1256	Prior History Of Known Cvd	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1257	Cvd Risk Assessment Not Performed Or Incomplete (E.G. Cvd Risk Assessment Was Not Documented) Reason Not Otherwise Specified	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024

M1258	Cvd Risk Assessment Performed Have A Documented Calculated Risk Score	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1259	Patients Listed On The Kidney-Pancreas Transplant Waitlist Or Who Received A Living Donor Transplant Within The First Year Following Initiation Of Dialysis	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1260	Patients Who Were Not Listed On The Kidney-Pancreas Transplant Waitlist Or Patients Who Did Not Receive A Living Donor Transplant Within The First Year Following Initiation Of Dialysis	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1261	Patients That Were On The Kidney Or Kidney-Pancreas Waitlist Prior To Initiation Of Dialysis	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1262	Patients Who Had A Transplant Prior To Initiation Of Dialysis	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1263	Patients In Hospice On Their Initiation Of Dialysis Date Or During The Month Of Evaluation	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1264	Patients Age 75 Or Older On Their Initiation Of Dialysis Date	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1265	Cms Medical Evidence Form 2728 For Dialysis Patients: Initial Form Completed	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1266	Patients Admitted To A Skilled Nursing Facility (Snf)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1267	Patients Not On Any Kidney Or Kidney-Pancreas Transplant Waitlist Or Is Not In Active Status On Any Kidney Or Kidney-Pancreas Transplant Waitlist As Of The Last Day Of Each Month During The Measurement Period	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1268	Patients On Active Status On Any Kidney Or Kidney-Pancreas Transplant Waitlist As Of The Last Day Of Each Month During The Measurement Period	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1269	Receiving Esrd Mcp Dialysis Services By The Provider On The Last Day Of The Reporting Month	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1270	Patients Not On Any Kidney Or Kidney-Pancreas Transplant Waitlist As Of The Last Day Of Each Month During The Measurement Period	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1271	Patients With Dementia At Any Time Prior To Or During The Month	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1272	Patients On Any Kidney Or Kidney-Pancreas Transplant Waitlist As Of The Last Day Of Each Month During The Measurement Period	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1273	Patients Who Were Admitted To A Skilled Nursing Facility (Snf) Within One Year Of Dialysis Initiation According To The Cms-2728 Form	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024

M1274	Patients Who Were Admitted To A Skilled Nursing Facility (Snf) During The Month Of Evaluation Were Excluded From That Month	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1275	Patients Determined To Be In Hospice Were Excluded From Month Of Evaluation And The Remainder Of Reporting Period	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1276	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.	1/1/2024	_	Add effective 01/01/2024
M1277	Colorectal Cancer Screening Results Documented And Reviewed	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1278	Elevated Or Hypertensive Blood Pressure Reading Documented And The Indicated Follow-Up Is Documented	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1279	Elevated Or Hypertensive Blood Pressure Reading Documented Indicated Follow-Up Not Documented Reason Not Given	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1280	Women Who Had A Bilateral Mastectomy Or Who Have A History Of A Bilateral Mastectomy Or For Whom There Is Evidence Of A Right And A Left Unilateral Mastectomy	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1281	Blood Pressure Reading Not Documented Reason Not Given	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1282	Patient Screened For Tobacco Use And Identified As A Tobacco Non-User	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1283	Patient Screened For Tobacco Use And Identified As A Tobacco User	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1284	Patients Age 66 Or Older In Institutional Special Needs Plans (Snp) Or Residing In Long Term Care With Pos Code 32 33 34 54 Or 56 For More Than 90 Consecutive Days During The Measurement Period	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1285	Screening Diagnostic Film Digital Or Digital Breast Tomosynthesis (3D) Mammography Results Were Not Documented And Reviewed Reason Not Otherwise Specified	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1286	Bmi Is Documented As Being Outside Of Normal Parameters Follow-Up Plan Is Not Completed For Documented Medical Reason	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1287	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.	1/1/2024	_	Add effective 01/01/2024
M1288	Documented Reason For Not Screening Or Recommending A Follow-Up For High Blood Pressure	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1289	Patient Identified As Tobacco User Did Not Receive Tobacco Cessation Intervention During The Measurement Period Or In The Six Months Prior To The Measurement Period (Counseling And/Or Pharmacotherapy)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1290	Patient Not Eligible Due To Active Diagnosis Of Hypertension	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024

M1291	Patients 66 Years Of Age And Older With At Least One Claim/Encounter For Frailty During The Measurement Period And A Dispensed Medication For Dementia During The Measurement Period Or The Year Prior To The Measurement Period	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1292	Patients 66 Years Of Age And Older With At Least One Claim/Encounter For Frailty During The Measurement Period And Either One Acute Inpatient Encounter With A Diagnosis Of Advanced Illness Or Two Outpatient Observation Ed Or Nonacute Inpatient Encounters On Different Dates Of Service With An Advanced Illness Diagnosis During The Measurement Period Or The Year Prior To The Measurement Period	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1293	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.	1/1/2024	_	Add effective 01/01/2024
M1294	Normal Blood Pressure Reading Documented Follow-Up Not Required	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1295	Patients With A Diagnosis Or Past History Of Total Colectomy Or Colorectal Cancer	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1296	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.	1/1/2024	_	Add effective 01/01/2024
M1297	Bmi Not Documented Due To Medical Reason Or Patient Refusal Of Height Or Weight Measurement	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1298	Documentation Of Patient Pregnancy Anytime During The Measurement Period Prior To And Including The Current Encounter	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1299	Influenza Immunization Administered Or Previously Received	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1300	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.	1/1/2024	_	Add effective 01/01/2024
M1301	Patient Identified As A Tobacco User Received Tobacco Cessation Intervention During The Measurement Period Or In The Six Months Prior To The Measurement Period (Counseling And/Or Pharmacotherapy)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1302	Screening Diagnostic Film Digital Or Digital Breast Tomosynthesis (3D) Mammography Results Documented And Reviewed	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1303	Hospice Services Provided To Patient Any Time During The Measurement Period	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1304	Patient Did Not Receive Any Pneumococcal Conjugate Or Polysaccharide Vaccine On Or After Their 19Th Birthday And Before The End Of The Measurement Period	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024

M1305	Patient Received Any Pneumococcal Conjugate Or Polysaccharide Vaccine On Or After Their 19Th Birthday And Before The End Of The Measurement Period	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1306	Patient Had Anaphylaxis Due To The Pneumococcal Vaccine Any Time During Or Before The Measurement Period	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1307	Documentation Stating The Patient Has Received Or Is Currently Receiving Palliative Or Hospice Care	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1308	Influenza Immunization Was Not Administered Reason Not Given	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1309	Palliative Care Services Provided To Patient Any Time During The Measurement Period	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1310	Patient Screened For Tobacco Use And Received Tobacco Cessation Intervention During The Measurement Period Or In The Six Months Prior To The Measurement Period (Counseling Pharmacotherapy Or Both) If Identified As A Tobacco User	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1311	Anaphylaxis Due To The Vaccine On Or Before The Date Of The Encounter	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1312	Patient Not Screened For Tobacco Use	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1313	Tobacco Screening Not Performed Or Tobacco Cessation Intervention Not Provided During The Measurement Period Or In The Six Months Prior To The Measurement Period	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1314	Bmi Not Documented And No Reason Is Given	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1315	Colorectal Cancer Screening Results Were Not Documented And Reviewed; Reason Not Otherwise Specified	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1316	Current Tobacco Non-User	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1317	Patients Who Are Counseled On Connection With A Csp And Explicitly Opt Out	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1318	Patients Who Did Not Have Documented Contact With A Csp For At Least One Of Their Screened Positive Hrsns Within 60 Days After Screening Or Documentation That There Was No Contact With A Csp	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1319	Patients Who Had Documented Contact With A Csp For At Least One Of Their Screened Positive Hrsns Within 60 Days After Screening	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1320	Patients Who Screened Positive For At Least 1 Of The 5 Hrsns	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1321	Patients Who Were Not Seen Within 7 Weeks Following The Date Of Injection For Follow Up Or Who Did Not Have A Documented Iop Or No Plan Of Care Documented If The Iop Was >25 Mm Hg	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024

M1322	Patients Seen Within 7 Weeks Following The Date Of Injection And Are Screened For Elevated Intraocular Pressure (Iop) With Tonometry With Documented Iop =<25 Mm Hg For Injected Eye	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1323	Patients Seen Within 7 Weeks Following The Date Of Injection And Are Screened For Elevated Intraocular Pressure (Iop) With Tonometry With Documented Iop >25 Mm Hg And A Plan Of Care Was Documented	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1324	Patients Who Had An Intravitreal Or Periocular Corticosteroid Injection (E.G. Triamcinolone Preservative-Free Triamcinolone Dexamethasone Dexamethasone Intravitreal Implant Or Fluocinolone Intravitreal Implant)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1325	Patients Who Were Not Seen For Reasons Documented By Clinician For Patient Or Medical Reasons (E.G. Inadequate Time For Follow-Up Patients Who Received A Prior Intravitreal Or Periocular Steroid Injection Within The Last Six (6) Months And Had A Subsequent Iop Evaluation With Iop <25Mm Hg Within Seven (7) Weeks Of Treatment)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1326	Patients With A Diagnosis Of Hypotony	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1327	Patients Who Were Not Appropriately Evaluated During The Initial Exam And/Or Who Were Not Re-Evaluated Within 8 Weeks	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1328	Patients With A Diagnosis Of Acute Vitreous Hemorrhage	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1329	Patients With A Post-Operative Encounter Of The Eye With The Acute Pvd Within 2 Weeks Before The Initial Encounter Or 8 Weeks After Initial Acute Pvd Encounter	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1330	Documentation Of Patient Reason(S) For Not Having A Follow Up Exam (E.G. Inadequate Time For Follow Up)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1331	Patients Who Were Appropriately Evaluated During The Initial Exam And Were Re-Evaluated No Later Than 8 Weeks From Initial Exam	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1332	Patients Who Were Not Appropriately Evaluated During The Initial Exam And/Or Who Were Not Re-Evaluated Within 2 Weeks	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1333	Acute Vitreous Hemorrhage	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1334	Patients With A Post-Operative Encounter Of The Eye With The Acute Pvd Within 2 Weeks Before The Initial Encounter Or 2 Weeks After Initial Acute Pvd Encounter	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1335	Documentation Of Patient Reason(S) For Not Having A Follow Up Exam (E.G. Inadequate Time For Follow Up)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1336	Patients Who Were Appropriately Evaluated During The Initial Exam And Were Re-Evaluated No Later Than 2 Weeks	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024

M1337	Acute Pvd	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1338	Patients Who Had Follow-Up Assessment 30 To 180 Days After The Index Assessment Who Did Not Demonstrate Positive Improvement Or Maintenance Of Functioning Scores During The Performance Period	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1339	Patients Who Had Follow-Up Assessment 30 To 180 Days After The Index Assessment Who Demonstrated Positive Improvement Or Maintenance Of Functioning Scores During The Performance Period	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1340	Index Assessment Completed Using The 12-Item Whodas 2.0 Or Sds During The Denominator Identification Period	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1341	Patients Who Did Not Have A Follow-Up Assessment Or Did Not Have An Assessment Within 30 To 180 Days After The Index Assessment During The Performance Period	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1342	Patients Who Died During The Performance Period	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1343	Patients Who Are At Pam Level 4 At Baseline Or Patients Who Are Flagged With Extreme Straight Line Response Sets On The Pam	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1344	Patients Who Did Not Have A Baseline Pam Score And/Or A Second Score Within 6 To 12 Month Of Baseline Pam Score	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1345	Patients Who Had A Baseline Pam Score And A Second Score Within 6 To 12 Month Of Baseline Pam Score	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1346	Patients Who Did Not Have A Net Increase In Pam Score Of At Least 6 Points Within A 6 To 12 Month Period	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1347	Patients Who Achieved A Net Increase In Pam Score Of At Least 3 Points In A 6 To 12 Month Period (Passing)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1348	Patients Who Achieved A Net Increase In Pam Score Of At Least 6-Points In A 6 To 12 Month Period (Excellent)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1349	Patients Who Did Not Have A Net Increase In Pam Score Of At Least 3 Points Within 6 To 12 Month Period	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1350	Patients Who Had A Completed Suicide Safety Plan Initiated Reviewed Or Updated In Collaboration With Their Clinician (Concurrent Or Within 24 Hours) Of The Index Clinical Encounter	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1351	Patients Who Had A Suicide Safety Plan Initiated Reviewed Or Updated And Reviewed And Updated In Collaboration With The Patient And Their Clinician Concurrent Or Within 24 Hours Of Clinical Encounter And Within 120 Days After Initiation	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1352	Suicidal Ideation And/Or Behavior Symptoms Based On The C-Ssrs Or Equivalent Assessment	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024

M1353	Patients Who Did Not Have A Completed Suicide Safety Plan Initiated Reviewed Or Updated In Collaboration With Their Clinician (Concurrent Or Within 24 Hours) Of The Index Clinical Encounter	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1354	Patients Who Did Not Have A Suicide Safety Plan Initiated Reviewed Or Updated Or Reviewed And Updated In Collaboration With The Patient And Their Clinician Concurrent Or Within 24 Hours Of Clinical Encounter And Within 120 Days After Initiation	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1355	Suicide Risk Based On Their Clinician'S Evaluation Or A Clinician-Rated Tool	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1356	Patients Who Died During The Measurement Period	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1357	Patients Who Had A Reduction In Suicidal Ideation And/Or Behavior Upon Follow-Up Assessment Within 120 Days Of Index Assessment	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1358	Patients Who Did Not Have A Reduction In Suicidal Ideation And/Or Behavior Upon Follow-Up Assessment Within 120 Days Of Index Assessment	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1359	Index Assessment During The Denominator Period When The Suicidal Ideation And/Or Behavior Symptoms Or Increased Suicide Risk By Clinician Determination Occurs And A Non-Zero C-Ssrs Score Is Obtained	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1360	Suicidal Ideation And/Or Behavior Symptoms Based On The C-Ssrs	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1361	Suicide Risk Based On Their Clinician'S Evaluation Or A Clinician-Rated Tool	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1362	Patients Who Died During The Measurement Period	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1363	Patients Who Did Not Have A Follow-Up Assessment Within 120 Days Of The Index Assessment	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1364	Calculated 10-Year Ascvd Risk Score Of >= 20 Percent During The Performance Period	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1365	Patient Encounter During The Performance Period With Hospice And Palliative Care Specialty Code 17	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1366	Focusing On Women'S Health Mips Value Pathway	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1367	Quality Care For The Treatment Of Ear Nose And Throat Disorders Mips Value Pathway	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1368	Prevention And Treatment Of Infectious Disorders Including Hepatitis C And Hiv Mips Value Pathway	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1369	Quality Care In Mental Health And Substance Use Disorders Mips Value Pathway	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024
M1370	Rehabilitative Support For Musculoskeletal Care Mips Value Pathway	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/1/2024	_	Add effective 01/01/2024

P2031	Hair Analysis (Excluding Arsenic)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
P9020	Platelet Rich Plasma Each Unit	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
P9099	Blood Component Or Product Not Otherwise Classified	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 Direct Qualitative Examinations Of Vaginal Or Cervical Mucous	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
Q0240	Injection Casirivimab And Imdevimab 600 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).	_	_	_
Q0243	Injection Casirivimab And Imdevimab 2400 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).	_	_	_
Q0244	Injection Casirivimab And Imdevimab 1200 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).	_	_	_
Q0245	Injection Bamlanivimab And Etesevimab 2100 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).	_	_	_
Q0477	Power Module Patient Cable For Use With Electric Or Electric/Pneumatic Ventricular Assist Device Replacement Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0478	Power Adapter For Use With Electric Or Electric/Pneumatic Ventricular Assist Device Vehicle Type	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

Q0479	Power Module For Use With Electric Or Electric/Pneumatic Ventricular Assist Device Replacement Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0480	Driver For Use With Pneumatic Ventricular Assist Device Replacement Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0481	Microprocessor Control Unit For Use With Electric Ventricular Assist Device Replacement Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0482	Microprocessor Control Unit For Use With Electric/Pneumatic Combination Ventricular Assist Device Replacement Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0483	Monitor/Display Module For Use With Electric Ventricular Assist Device Replacement Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0484	Monitor/Display Module For Use With Electric Or Electric/Pneumatic Ventricular Assist Device Replacement Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0485	Monitor Control Cable For Use With Electric Ventricular Assist Device Replacement Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0486	Monitor Control Cable For Use With Electric/Pneumatic Ventricular Assist Device Replacement Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0487	Leads (Pneumatic/Electrical) For Use With Any Type Electric/Pneumatic Ventricular Assist Device Replacement Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

Q0488	Power Pack Base For Use With Electric Ventricular Assist Device Replacement Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0489	Power Pack Base For Use With Electric/Pneumatic Ventricular Assist Device Replacement Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0490	Emergency Power Source For Use With Electric Ventricular Assist Device Replacement Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0491	Emergency Power Source For Use With Electric/Pneumatic Ventricular Assist Device Replacement Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0492	Emergency Power Supply Cable For Use With Electric Ventricular Assist Device Replacement Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0493	Emergency Power Supply Cable For Use With Electric/Pneumatic Ventricular Assist Device Replacement Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0494	Emergency Hand Pump For Use With Electric Or Electric/Pneumatic Ventricular Assist Device Replacement Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0495	Battery/Power Pack Charger For Use With Electric Or Electric/Pneumatic Ventricular Assist Device Replacement Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0496	Battery Other Than Lithium-Ion For Use With Electric Or Electric/Pneumatic Ventricular Assist Device Replacement Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

Q0497	Battery Clips For Use With Electric Or Electric/Pneumatic Ventricular Assist Device Replacement Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0498	Holster For Use With Electric Or Electric/Pneumatic Ventricular Assist Device Replacement Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0499	Belt/Vest/Bag For Use To Carry External Peripheral Components Of Any Type Ventricular Assist Device Replacement Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0500	Filters For Use With Electric Or Electric/Pneumatic Ventricular Assist Device Replacement Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0501	Shower Cover For Use With Electric Or Electric/Pneumatic Ventricular Assist Device Replacement Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0502	Mobility Cart For Pneumatic Ventricular Assist Device Replacement Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0503	Battery For Pneumatic Ventricular Assist Device Replacement Only Each	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0504	Power Adapter For Pneumatic Ventricular Assist Device Replacement Only Vehicle Type	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q0506	Battery Lithium-Ion For Use With Electric Or Electric/Pneumatic Ventricular Assist Device Replacement Only	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

Q0507	Miscellaneous Supply Or Accessory For Use With An External Ventricular Assist Device	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
Q0508	Miscellaneous Supply Or Accessory For Use With An Implanted Ventricular Assist Device	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
Q0509	Miscellaneous Supply Or Accessory For Use With Any Implanted Ventricular Assist Device For Which Payment Was Not Made Under Medicare Part A	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
Q0516	Pharmacy Supplying Fee For Hiv Pre-Exposure Prophylaxis Fda Approved Prescription Drug Per 30-Days	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/2/2024	_	Add effective 01/02/2024
Q0517	Pharmacy Supplying Fee For Hiv Pre-Exposure Prophylaxis Fda Approved Prescription Drug Per 60-Days	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/2/2024	_	Add effective 01/02/2024
Q0518	Pharmacy Supplying Fee For Hiv Pre-Exposure Prophylaxis Fda Approved Prescription Drug Per 90-Days	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	1/2/2024	_	Add effective 01/02/2024
Q2026	Injection Radiesse 0.1 Ml	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q2028	Injection Sculptra 0.5 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q2039	Influenza Virus Vaccine Not Otherwise Specified	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_

Q2041	Axicabtagene Ciloleucel Up To 200 Million Autologous Anti-Cd19 Car Positive Viable T Cells Including Leukapheresis And Dose Preparation Procedures Per Therapeutic Dose	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
Q2050	Injection Doxorubicin Hydrochloride Liposomal Not Otherwise Specified 10Mg	Unlisted Procedure; May require Prior Authorization per contract agreement.	_	_	_
Q2052	Services Supplies And Accessories Used In The Home For The Administration Of Intravenous Immune Globulin (Ivig)	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	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
Q2054	Lisocabtagene Maraleucel Up To 110 Million Autologous Anti-Cd19 Car-Positive Viable T Cells Including Leukapheresis And Dose Preparation Procedures Per Therapeutic Dose	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
Q2055	Idecabtagene Vicleucel Up To 460 Million Autologous B-Cell Maturation Antigen (Bcma) Directed Car-Positive T Cells Including Leukapheresis And Dose Preparation Procedures Per Therapeutic Dose	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
Q2056	Ciltacabtagene Autoleucel Up To 100 Million Autologous B-Cell Maturation Antigen (Bcma) Directed Car-Positive T Cells Including Leukapheresis And Dose Preparation Procedures Per Therapeutic Dose	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
Q4050	Cast Supplies For Unlisted Types And Materials Of Casts	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
Q4051	Splint Supplies Miscellaneous (Includes Thermoplastics Strapping Fasteners Padding And Other Supplies)	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
Q4082	Drug Or Biological Not Otherwise Classified Part B Drug Competitive Acquisition Program (Cap)	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review. Unlisted or Undefined	_	_	_

Q4100	Skin Substitute Not Otherwise Specified	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
Q4101	Apligraf Per Square Centimeter	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q4102	Oasis Wound Matrix Per Square Centimeter	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q4103	Oasis Burn Matrix 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).	_	_	_
Q4104	Integra Bilayer Matrix Wound Dressing (Bmwd) 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).	_	_	_
Q4105	Integra Dermal Regeneration Template (Drt) Or Integra Omnigraft Dermal Regeneration Matrix Per Square Centimeter	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q4106	Dermagraft Per Square Centimeter	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q4107	Graftjacket Per Square Centimeter	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q4108	Integra Matrix Per Square Centimeter	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

Q4110	Primatrix 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).	_	_	_
Q4111	Gammagraft 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).	_	_	_
Q4112	Cymetra Injectable 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).	_	_	_
Q4113	Graftjacket Xpress Injectable 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).	_	_	_
Q4114	Integra Flowable Wound Matrix Injectable 1Cc	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q4115	Alloskin 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).	_	_	_
Q4116	Alloderm Per Square Centimeter	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q4117	Hyalomatrix 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).	_	_	_
Q4118	Matristem Micromatrix 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).	_	_	_
Q4121	Theraskin 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).	_	_	_
Q4122	Dermacell Dermacell Awm Or Dermacell Awm Porous Per Square Centimeter	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

Q4123	Alloskin Rt Per Square Centimeter	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4124	Oasis Ultra Tri-Layer Wound Matrix Per Square Centimeter	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4125	Arthroflex Per Square Centimeter	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4126	Memoderm Dermaspan Tranzgraft Or Integuply 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).	_	_	_
Q4127	Talymed Per Square Centimeter	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4128	Flex Hd Or Allopatch Hd Per Square Centimeter	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q4130	Strattice Tm Per Square Centimeter	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4132	Grafix Core And Grafixpl Core Per Square Centimeter	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q4133	Grafix Prime Grafixpl Prime Stravix And Stravixpl Per Square Centimeter	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q4134	Hmatrix 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).	_	_	_
Q4135	Mediskin 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).	_	_	_

Q4136	Ez-Derm 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).	_	_	_
Q4137	Amnioexcel Amnioexcel Plus Or Biodexcel 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).	_	_	_
Q4138	Biodfence Dryflex 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).	_	_	_
Q4139	Amniomatrix Or Biodmatrix Injectable 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).	_	_	_
Q4140	Biodfence 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).	_	_	_
Q4141	Alloskin Ac 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).	_	_	_
Q4142	Xcm Biologic Tissue 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).	_	_	_
Q4143	Repriza 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).	_	_	_
Q4145	Epifix Injectable 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).	_	_	_
Q4146	Tensix 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).	_	_	_
Q4147	Architect Architect Px Or Architect Fx Extracellular 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).	_	_	_

Q4148	Neox Cord 1K Neox Cord Rt Or Clarix Cord 1K 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).	_	_	_
Q4149	Excellagen 0.1 Cc	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4150	Allowrap Ds Or Dry 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).	_	_	_
Q4151	Amnioband Or Guardian Per Square Centimeter	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q4152	Dermapure 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).	_	_	_
Q4153	Dermavest And Plurivest 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).	_	_	_
Q4154	Biovance Per Square Centimeter	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q4155	Neoxflo Or Clarixflo 1 Mg	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4156	Neox 100 Or Clarix 100 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).	_	_	_
Q4157	Revitalon 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).	_	_	_
Q4158	Kerecis Omega3 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).	_	_	_

Q4159	Affinity Per Square Centimeter	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q4160	Nushield 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).	_	_	_
Q4161	Bio-Connekt 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).	_	_	_
Q4162	Woundex Flow Bioskin Flow 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).	_	_	_
Q4163	Woundex Bioskin 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).	_	_	_
Q4164	Helicoll 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).	_	_	_
Q4165	Keramatrix Or Kerasorb 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).	_	_	_
Q4166	Cytal Per Square Centimeter	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4167	Truskin Per 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).	_	_	_
Q4168	Amnioband 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q4169	Artacent Wound Per 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).	_	_	_

Q4170	Cygnus 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).	_	_	_
Q4171	Interfyl 1 Mg	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4173	Palingen Or Palingen Xplus 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).	_	_	_
Q4174	Palingen Or Promatrx 0.36 Mg Per 0.25 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).	_	_	_
Q4175	Miroderm 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).	_	_	_
Q4176	Neopatch Or Therion Per Square Centimeter	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4177	Floweramnioflo 0.1 Cc	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4178	Floweramniopatch Per 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).	_	_	_
Q4179	Flowerderm 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).	_	_	_
Q4180	Revita 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).	_	_	_
Q4181	Amnio Wound 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).	_	_	_

Q4182	Transcyte 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).	_	_	_
Q4183	Surgigraft 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).	_	_	_
Q4184	Cellesta Or Cellesta Duo 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).	_	_	_
Q4185	Cellesta Flowable Amnion (25 Mg Per Cc); 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).	_	_	_
Q4186	Epifix Per Square Centimeter	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q4187	Epicord Per Square Centimeter	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q4188	Amnioarmor 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).	_	_	_
Q4189	Artacent Ac 1 Mg	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4190	Artacent Ac 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).	_	_	_
Q4191	Restorigin 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).	_	_	_
Q4192	Restorigin 1 Cc	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_

Q4193	Coll-E-Derm 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).	_	_	_
Q4194	Novachor 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).	_	_	_
Q4195	Puraply 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).	_	_	_
Q4196	Puraply Am 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).	_	_	_
Q4197	Puraply Xt 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).	_	_	_
Q4198	Genesis Amniotic Membrane 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).	_	_	_
Q4199	Cygnus 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).	_	_	_
Q4200	Skin Te 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).	_	_	_
Q4201	Matrion 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).	_	_	_
Q4202	Keroxx (2.5G/Cc) 1Cc	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4203	Derma-Gide 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).	_	_	_

Q4204	Xwrap 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).	_	_	_
Q4205	Membrane Graft Or Membrane Wrap 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).	_	_	_
Q4206	Fluid Flow Or Fluid Gf 1 Cc	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4208	Novafix Per Square Cenitmeter	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4209	Surgraft Per 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).	_	_	_
Q4210	Axolotl Graft Or Axolotl Dualgraft 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).	_	_	_
Q4211	Amnion Bio Or Axobiomembrane 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).	_	_	_
Q4212	Allogen Per Cc	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4213	Ascent 0.5 Mg	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4214	Cellesta Cord Per 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).	_	_	_
Q4215	Axolotl Ambient Or Axolotl Cryo 0.1 Mg	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_

Q4216	Artacent Cord Per 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).	_	_	_
Q4217	Woundfix Biowound Woundfix Plus Biowound Plus Woundfix Xplus Or Biowound Xplus 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).	_	_	_
Q4218	Surgicord 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).	_	_	_
Q4219	Surgigraft-Dual 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).	_	_	_
Q4220	Bellacell Hd Or Surederm 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).	_	_	_
Q4221	Amniowrap2 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).	_	_	_
Q4222	Progenamatrix 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).	_	_	_
Q4224	Human Health Factor 10 Amniotic Patch (Hhf10-P) 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).	_	_	_
Q4225	Amniobind Or Dermabind Tl 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).	_	_	_
Q4227	Amniocore 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).	_	_	_
Q4229	Cogenex Amniotic Membrane 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).	_	_	_

Q4230	Cogenex Flowable Amnion 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).	_	_	_
Q4231	Corplex P Per Cc	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4232	Corplex Per 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).	_	_	_
Q4233	Surfactor Or Nudyn Per 0.5 Cc	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4234	Xcellerate Per 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).	_	_	_
Q4235	Amniorepair Or Altiply 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).	_	_	_
Q4236	Carepatch 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).	_	_	_
Q4237	Cryo-Cord 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).	_	_	_
Q4238	Derm-Maxx 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).	_	_	_
Q4239	Amnio-Maxx Or Amnio-Maxx Lite 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).	_	_	_
Q4240	Corecyte For Topical Use Only 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).	_	_	_

Q4241	Polycyte For Topical Use Only 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).	_	_	_
Q4242	Amniocyte Plus Per 0.5 Cc	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4244	Procenta, per 200 mg	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	3/31/2024	Retire effective 03/31/2024
Q4245	Amniotext Per Cc	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4246	Coretext Or Protext Per Cc	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4247	Amniotext Patch Per 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).	_	_	_
Q4248	Dermacyte Amniotic Membrane Allograft 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).	_	_	_
Q4249	Amniply For Topical Use Only 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).	_	_	_
Q4250	Amnioamp-Mp 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).	_	_	_
Q4251	Vim Per Square Centimeter	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4252	Vendaje Per Square 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).	_	_	_

Q4253	Zenith Amniotic Membrane 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).	_	_	_
Q4254	Novafix Dl 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).	_	_	_
Q4255	Reguard For Topical Use Only 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).	_	_	_
Q4256	Mlg-Complete 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).	_	_	_
Q4257	Relese 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).	_	_	_
Q4258	Enverse 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).	_	_	_
Q4259	Celera Dual Layer Or Celera Dual Membrane 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).	_	_	_
Q4260	Signature Apatch 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).	_	_	_
Q4261	Tag Per Square Centimeter	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
Q4262	Dual Layer Impax Membrane Per Square Centimeter	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q4263	Surgraft Tl Per Square Centimeter	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

Q4264	Cocoon Membrane Per Square Centimeter	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q4265	Neostim Tl 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).	_	_	_
Q4266	Neostim Membrane 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).	_	_	_
Q4267	Neostim Dl 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).	_	_	_
Q4268	Surgraft Ft 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).	_	_	_
Q4269	Surgraft Xt 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).	_	_	_
Q4270	Complete Sl 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).	_	_	_
Q4271	Complete Ft 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).	_	_	_
Q4272	Esano A 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).	_	_	_
Q4273	Esano Aaa 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).	_	_	_
Q4274	Esano Ac 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).	_	_	_

Q4275	Esano Aca 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).	_	_	_
Q4276	Orion 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).	_	_	_
Q4277	Woundplus Membrane Or E-Graft 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).	_	_	_
Q4278	Epieffect 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).	_	_	_
J7178	Injection Human Fibrinogen Concentrate Not Otherwise Specified 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical		6/30/2024	Retire Effective 6/30/2024
Q4279	Vendaje Ac Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	6/30/2024	Add effective 01/01/2024 Retire effective 06/30/2024
Q4280	Xcell Amnio 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).	_	_	_
Q4281	Barrera Sl Or Barrera Dl 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).	_	_	_
Q4282	Cygnus Dual 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).	_	_	_
Q4283	Biovance Tri-Layer Or Biovance 3L 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).	_	_	_
Q4284	Dermabind Sl 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).	_	_	_

Q4285	Nudyn Dl Or Nudyn Dl Mesh 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).	_	_	_
Q4286	Nudyn Sl Or Nudyn Slw 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).	_	_	_
Q4279	Vendaje Ac Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
Q4287	Dermabind Dl Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	6/30/2024	Add effective 01/01/2024 Retire effective 06/30/2024
Q4287	Dermabind Dl Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
Q4288	Dermabind Ch Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	6/30/2024	Add effective 01/01/2024 Retire effective 06/30/2024
Q4288	Dermabind Ch Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
Q4289	Revoshield + Amniotic Barrier Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	6/30/2024	Add effective 01/01/2024 Retire effective 06/30/2024
Q4289	Revoshield + Amniotic Barrier Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
Q4290	Membrane Wrap-Hydro Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	6/30/2024	Add effective 01/01/2024 Retire effective 06/30/2024
Q4290	Membrane Wrap-Hydro Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
Q4291	Lamellas Xt Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	6/30/2024	Add effective 01/01/2024 Retire effective 06/30/2024
Q4291	Lamellas Xt Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024

Q4292	Lamellas Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	6/30/2024	Add effective 01/01/2024 Retire effective 06/30/2024
Q4292	Lamellas Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
Q4293	Acesso Dl Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	6/30/2024	Add effective 01/01/2024 Retire effective 06/30/2024
Q4293	Acesso Dl Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
Q4294	Amnio Quad-Core Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	6/30/2024	Add effective 01/01/2024 Retire effective 06/30/2024
Q4294	Amnio Quad-Core Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
Q4295	Amnio Tri-Core Amniotic Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	6/30/2024	Add effective 01/01/2024 Retire effective 06/30/2024
Q4295	Amnio Tri-Core Amniotic Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
Q4296	Rebound Matrix Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	6/30/2024	Add effective 01/01/2024 Retire effective 06/30/2024
Q4296	Rebound Matrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
Q4297	Emerge Matrix Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	6/30/2024	Add effective 01/01/2024 Retire effective 06/30/2024
Q4297	Emerge Matrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
Q4298	Amnicore Pro Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	6/30/2024	Add effective 01/01/2024 Retire effective 06/30/2024

Q4298	Amnicore Pro Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
Q4299	Amnicore Pro+ Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	6/30/2024	Add effective 01/01/2024 Retire effective 06/30/2024
Q4299	Amnicore Pro+ Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
Q4300	Acesso Tl Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	6/30/2024	Add effective 01/01/2024 Retire effective 06/30/2024
Q4300	Acesso Tl Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
Q4301	Activate Matrix Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	6/30/2024	Add effective 01/01/2024 Retire effective 06/30/2024
Q4301	Activate Matrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
Q4302	Complete Aca Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	6/30/2024	Add effective 01/01/2024 Retire effective 06/30/2024
Q4302	Complete Aca Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024
Q4303	Complete Aa Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	6/30/2024	Add effective 01/01/2024 Retire effective 06/30/2024
Q4304	Grafix Plus Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	1/1/2024	_	Add effective 01/01/2024
Q4305	American Amnion Ac Tri-Layer Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2024	_	Add effective 04/01/2024
Q4306	American Amnion Ac Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2024	_	Add effective 04/01/2024
Q4307	American Amnion Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2024	_	Add effective 04/01/2024

Q4308	Sanopellis Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2024	_	Add effective 04/01/2024
Q4309	Via Matrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2024	_	Add effective 04/01/2024
Q4310	Procenta Per 100 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	4/1/2024	_	Add effective 04/01/2024
Q5009	Hospice Or Home Health Care Provided In Place Not Otherwise Specified (Nos)	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
Q5103	Injection Infliximab-Dyyb Biosimilar (Inflectra) 10 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
Q5106	Injection Epoetin Alfa-Epbx Biosimilar (Retacrit) (For Non-Esrd Use) 1000 Units	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	_	_	_
Q5109	Injection Infliximab-Qbtx Biosimilar (Ixifi) 10 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
Q5124	Injection Ranibizumab-Nuna Biosimilar (Byooviz) 0.1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q5128	Injection Ranibizumab-Eqrn (Cimerli) Biosimilar 0.1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q5131	Injection Adalimumab-Aacf (Idacio) Biosimilar 20 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q5133	Injection Tocilizumab-Bavi (Tofidence) Biosimilar 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2024	_	Add effective 8/1/2024

Q5134	Injection Natalizumab-Sztn (Tyruko) Biosimilar 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2024	_	Add effective 4/1/2024
Q9004	Department Of Veterans Affairs Whole Health Partner Services	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
Q9982	Flutemetamol F18 Diagnostic Per Study Dose Up To 5 Millicuries	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
Q9983	Florbetaben F18 Diagnostic Per Study Dose Up To 8.1 Millicuries	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S0013	Esketamine Nasal Spray 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S0122	Injection Menotropins 75 Iu	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S0126	Injection Follitropin Alfa 75 Iu	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S0128	Injection Follitropin Beta 75 Iu	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S0155	Sterile Dilutant For Epoprostenol 50Ml	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S0157	Becaplermin Gel 0. 01% 0. 5 Gm	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
S0189	Testosterone Pellet 75Mg	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Prior Authorization may be required per contract agreement.	_	_	_
S0194	Dialysis/Stress Vitamin Supplement Oral100 Capsules	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S0197	Prenatal Vitamins 30-Day Supply	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_

S0207	Paramedic Intercept Non-Hospital-Based Als Service (Non-Voluntary) Non-Transport	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S0209	Wheelchair Van Mileage Per Mile	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S0215	Non-Emergency Transportation; Mileage Per Mile	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S0257	Counseling And Discussion Regarding Advance Directives Or End Of Life Care Planning And Decisions With Patient And/Or Surrogate (List Separately In Addition To Code For Appropriate Evaluation And Management Service)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S0315	Disease Management Program; Initial Assessment And Initiation Of The Program	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S0316	Disease Management Program; Follow-Up/Reassessment	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S0317	Disease Management Program; Per Diem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S0320	Telephone Calls By A Registered Nurse To A Disease Management Program Member For Monitoring Purposes; Per Month	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S0390	Routine Foot Care; Removal And/Or Trimming Of Corns Calluses And/Or Nails And Preventive Maintenance In Specific Medical Conditions (E. G. Diabetes) Per Visit	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S0510	Non-Prescription Lens (Safety Athletic Or Sunglass) Per Lens	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S0514	Color Contact Lens Per Lens	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S0516	Safety Eyeglass Frames	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S0518	Sunglasses Frames	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S0590	Integral Lens Service Miscellaneous Services Reported Separately	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
S0596	Phakic Intraocular Lens For Correction Of Refractive Error	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

S0622	Physical Exam For College New Or Established Patient (List Separately In Addition To Appropriate Evaluation And Management Code)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S0800	Laser In Situ Keratomileusis (Lasik)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S0810	Photorefractive Keratectomy (Prk)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S0812	Phototherapeutic Keratectomy (Ptk)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S1001	Deluxe Item Patient Aware (List In Addition To Code For Basic Item)	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
S1002	Customized Item (List In Addition To Code For Basic Item)	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
S1030	Continuous Noninvasive Glucose Monitoring Device Purchase (For Physician Interpretation Of Data Use Cpt Code)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S1031	Continuous Noninvasive Glucose Monitoring Device Rental Including Sensor Sensor Replacement And Download To Monitor (For Physician Interpretation Of Data Use Cpt Code)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S1034	Artificial Pancreas Device System (Eg Low Glucose Suspend [Lgs] Feature) Including Continuous Glucose Monitor Blood Glucose Device Insulin Pump And Computer Algorithm That Communicates With All Of The Devices	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S1035	Sensor; Invasive (Eg Subcutaneous) Disposable For Use With Artificial Pancreas Device System 1 Unit = 1 Day Supply	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S1036	Transmitter; External For Use With Artificial Pancreas Device System	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

S1037	Receiver (Monitor); External For Use With Artificial Pancreas Device System	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S1040	Cranial Remolding Orthosis Pediatric Rigid With Soft Interface Material Custom Fabricated Includes Fitting And Adjustment(S)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S1091	Stent Non-Coronary Temporary With Delivery System (Propel)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S2080	Laser-Assisted Uvulopalatoplasty (Laup)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S2083	Adjustment Of Gastric Band Diameter Via Subcutaneous Port By Injection Or Aspiration Of Saline	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S2095	Transcatheter Occlusion Or Embolization For Tumor Destruction Percutaneous Any Method Using Yttrium-90 Microspheres	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S2102	Islet Cell Tissue Transplant From Pancreas; Allogeneic	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S2103	Adrenal Tissue Transplant To Brain	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S2107	Adoptive Immunotherapy I. E. Development Of Specific Anti-Tumor Reactivity (E. G. Tumor-Infiltrating Lymphocyte Therapy) Per Course Of Treatment	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

S2112	Arthroscopy Knee Surgical For Harvesting Of Cartilage (Chondrocyte Cells)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S2117	Arthroereisis Subtalar	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
S2140	Cord Blood Harvesting For Transplantation Allogeneic	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S2142	Cord Blood-Derived Stem-Cell Transplantation Allogeneic	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S2150	Bone Marrow Or Blood-Derived Stem Cells (Peripheral Or Umbilical) Allogeneic Or Autologous Harvesting Transplantation And Related Complications; Including: Pheresis And Cell Preparation/Storage; Marrow Ablative Therapy; Drugs Supplies Hospitalization With Outpatient Follow-Up; Medical/Surgical Diagnostic Emergency And Rehabilitative Services; And The Number Of Days Of Pre-And Post-Transplant Care In The Global Definition	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S2202	Echosclerotherapy	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S2230	Implantation Of Magnetic Component Of Semi-Implantable Hearing Device On Ossicles In Middle Ear	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S2235	Implantation Of Auditory Brain Stem Implant	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S2300	Arthroscopy Shoulder Surgical; With Thermally-Induced Capsulorrhaphy	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_

S2348	Decompression Procedure Percutaneous Of Nucleus Pulposus Of Intervertebral Disc Using Radiofrequency Energy Single Or Multiple Levels Lumbar	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S2400	Repair Congenital Diaphragmatic Hernia In The Fetus Using Temporary Tracheal Occlusion Procedure Performed In Utero	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S2401	Repair Urinary Tract Obstruction In The Fetus Procedure Performed In Utero	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S2402	Repair Congenital Cystic Adenomatoid Malformation In The Fetus Procedure Performed In Utero	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S2403	Repair Extralobar Pulmonary Sequestration In The Fetus Procedure Performed In Utero	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S2404	Repair Myelomeningocele In The Fetus Procedure Performed In Utero	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S2405	Repair Of Sacrococcygeal Teratoma In The Fetus Procedure Performed In Utero	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S2409	Repair Congenital Malformation Of Fetus Procedure Performed In Utero Not Otherwise Classified	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_

S2411	Fetoscopic Laser Therapy For Treatment Of Twin-To-Twin Transfusion Syndrome	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S3650	Saliva Test Hormone Level; During Menopause	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
S3652	Saliva Test Hormone Level; To Assess Preterm Labor Risk	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
S3655	Antisperm Antibodies Test (Immunobead)	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	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S3900	Surface Electromyography (Emg)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
S4005	Interim Labor Facility Global (Labor Occurring But Not Resulting In Delivery)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4011	In Vitro Fertilization; Including But Not Limited To Identification And Incubation Of Mature Oocytes Fertilization With Sperm Incubation Of Embryo(S) And Subsequent Visualization For Determination Of Development	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4013	Complete Cycle Gamete Intrafallopian Transfer (Gift) Case Rate	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4014	Complete Cycle Zygote Intrafallopian Transfer (Zift) Case Rate	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4015	Complete In Vitro Fertilization Cycle Not Otherwise Specified Case Rate	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review. Unlisted or Undefined	_	_	_
S4016	Frozen In Vitro Fertilization Cycle Case Rate	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4017	Incomplete Cycle Treatment Cancelled Prior To Stimulation Case Rate	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4018	Frozen Embryo Transfer Procedure Cancelled Before Transfer Case Rate	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4020	In Vitro Fertilization Procedure Cancelled Before Aspiration Case Rate	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_

S4021	In Vitro Fertilization Procedure Cancelled After Aspiration Case Rate	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4022	Assisted Oocyte Fertilization Case Rate	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4023	Donor Egg Cycle Incomplete Case Rate	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4025	Donor Services For In Vitro Fertilization (Sperm Or Embryo) Case Rate	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4026	Procurement Of Donor Sperm From Sperm Bank	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4027	Storage Of Previously Frozen Embryos	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4028	Microsurgical Epididymal Sperm Aspiration (Mesa)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4030	Sperm Procurement And Cryopreservation Services; Initial Visit	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4031	Sperm Procurement And Cryopreservation Services; Subsequent Visit	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4035	Stimulated Intrauterine Insemination (Iui) Case Rate	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4037	Cryopreserved Embryo Transfer Case Rate	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4040	Monitoring And Storage Of Cryopreserved Embryos Per 30 Days	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4042	Management Of Ovulation Induction (Interpretation Of Diagnostic Tests And Studies Non-Face-To-Face Medical Management Of The Patient) Per Cycle	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4988	Penile Contracture Device Manual Greater Than 3 Lbs Traction Force	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2024	_	Add effective 4/1/2024
S4990	Nicotine Patches Legend	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S4991	Nicotine Patches Non-Legend	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	Day Care Services Adult; Per 15 Minutes	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5101	Day Care Services Adult; Per Half Day	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5102	Day Care Services Adult; Per Diem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5105	Day Care Services Center-Based; Services Not Included In Program Fee Per Diem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5108	Home Care Training To Home Care Client Per 15 Minutes	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_

S5109	Home Care Training To Home Care Client Per Session	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5110	Home Care Training Family; Per 15 Minutes	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5111	Home Care Training Family; Per Session	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5115	Home Care Training Non-Family; Per 15 Minutes	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5116	Home Care Training Non-Family; Per Session	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5120	Chore Services; Per 15 Minutes	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 Services; Per 15 Minutes	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5126	Attendant Care Services; Per Diem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5130	Homemaker Service Nos; Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review. Unlisted or Undefined	_	_	_
S5131	Homemaker Service Nos; Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review. Unlisted or Undefined	_	_	_
S5135	Companion Care Adult (E. G. Iadl/Adl); Per 15 Minutes	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5136	Companion Care Adult (E. G. Iadl/Adl); Per Diem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5140	Foster Care Adult; Per Diem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5141	Foster Care Adult; Per Month	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5145	Foster Care Therapeutic Child; Per Diem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5146	Foster Care Therapeutic Child; Per Month	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5150	Unskilled Respite Care Not Hospice; Per 15 Minutes	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5151	Unskilled Respite Care Not Hospice; Per Diem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5160	Emergency Response System; Installation And Testing	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5161	Emergency Response System; Service Fee Per Month (Excludes Installation And Testing)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5162	Emergency Response System; Purchase Only	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_

S5165	Home Modifications; Per Service	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5170	Home Delivered Meals Including Preparation; Per Meal	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5175	Laundry Service External Professional; Per Order	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5181	Home Health Respiratory Therapy Nos Per Diem	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
S5185	Medication Reminder Service Non-Face-To-Face; Per Month	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S5199	Personal Care Item Nos Each	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review. Unlisted or Undefined	_	_	_
S5497	Home Infusion Therapy Catheter Care / Maintenance Not Otherwise Classified; Includes Administrative Services Professional Pharmacy Services Care Coordination And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately) Per Diem	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
S8035	Magnetic Source Imaging	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S8040	Topographic Brain Mapping	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S8080	Scintimammography (Radioimmunoscintigraphy Of The Breast) Unilateral Including Supply Of Radiopharmaceutical	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S8130	Interferential Current Stimulator 2 Channel	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
S8131	Interferential Current Stimulator 4 Channel	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
S8185	Flutter Device	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

S8189	Tracheostomy Supply Not Otherwise Classified	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
S8270	Enuresis Alarm Using Auditory Buzzer And/Or Vibration Device	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S8301	Infection Control Supplies Not Otherwise Specified	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
S8930	Electrical Stimulation Of Auricular Acupuncture Points; Each 15 Minutes Of Personal One-On-One Contact With The Patient	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S8940	Equestrian/Hippotherapy Per Session	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
S8948	Application Of A Modality (Requiring Constant Provider Attendance) To One Or More Areas; Low-Level Laser; Each 15 Minutes	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S8990	Physical Or Manipulative Therapy Performed For Maintenance Rather Than Restoration	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S9001	Home Uterine Monitor With Or Without Associated Nursing Services	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
S9002	Intra-Vaginal Motion Sensor System Provides Biofeedback For Pelvic Floor Muscle Rehabilitation Device	MP Criteria: Procedure/service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	4/1/2024	_	Add effectuce 04/01/2024
S9055	Procuren Or Other Growth Factor Preparation To Promote Wound Healing	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S9056	Coma Stimulation Per Diem	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	_	_	_
S9090	Vertebral Axial Decompression 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).	_	_	_

S9117	Back School Per Visit	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S9125	Respite Care In The Home Per Diem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S9128	Speech Therapy In The Home Per Diem	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S9129	Occupational Therapy In The Home Per Diem	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S9131	Physical Therapy; In The Home Per Diem	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S9145	Insulin Pump Initiation Instruction In Initial Use Of Pump (Pump Not Included)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S9335	Home Therapy Hemodialysis; Administrative Services Professional Pharmacy Services Care Coordination And All Necessary Supplies And Equipment (Drugs And Nursing Services Coded Separately) Per Diem	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S9340	Home Therapy; Enteral Nutrition; Administrative Services Professional Pharmacy Services Care Coordination And All Necessary Supplies And Equipment (Enteral Formula And Nursing Visits Coded Separately) Per Diem	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S9341	Home Therapy; Enteral Nutrition Via Gravity; Administrative Services Professional Pharmacy Services Care Coordination And All Necessary Supplies And Equipment (Enteral Formula And Nursing Visits Coded Separately) Per Diem	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S9342	Home Therapy; Enteral Nutrition Via Pump; Administrative Services Professional Pharmacy Services Care Coordination And All Necessary Supplies And Equipment (Enteral Formula And Nursing Visits Coded Separately) Per Diem	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

S9343	Home Therapy; Enteral Nutrition Via Bolus; Administrative Services Professional Pharmacy Services Care Coordination And All Necessary Supplies And Equipment (Enteral Formula And Nursing Visits Coded Separately) Per Diem	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S9355	Home Infusion Therapy Chelation Therapy; Administrative Services Professional Pharmacy Services Care Coordination And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately) Per Diem	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S9364	Home Infusion Therapy Total Parenteral Nutrition (Tpn); Administrative Services Professional Pharmacy Services Care Coordination And All Necessary Supplies And Equipment Including Standard Tpn Formula (Lipids Specialty Amino Acid Formulas Drugs Other Than In Standard Formula And Nursing Visits Coded Separately) Per Diem (Do Not Use With Home Infusion Codes S9365-S9368 Using Daily Volume Scales)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S9366	Home Infusion Therapy Total Parenteral Nutrition (Tpn); More Than One Liter But No More Than Two Liters Per Day Administrative Services Professional Pharmacy Services Care Coordination And All Necessary Supplies And Equipment Including Standard Tpn Formula (Lipids Specialty Amino Acid Formulas Drugs Other Than In Standard Formula And Nursing Visits Coded Separately) Per Diem	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S9367	Home Infusion Therapy Total Parenteral Nutrition (Tpn); More Than Two Liters But No More Than Three Liters Per Day Administrative Services Professional Pharmacy Services Care Coordination And All Necessary Supplies And Equipment Including Standard Tpn Formula (Lipids Specialty Amino Acid Formulas Drugs Other Than In Standard Formula And Nursing Visits Coded Separately) Per Diem	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S9368	Home Infusion Therapy Total Parenteral Nutrition (Tpn); More Than Three Liters Per Day Administrative Services Professional Pharmacy Services Care Coordination And All Necessary Supplies And Equipment Including Standard Tpn Formula (Lipids Specialty Amino Acid Formulas Drugs Other Than In Standard Formula And Nursing Visits Coded Separately) Per Diem	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S9379	Home Infusion Therapy Infusion Therapy Not Otherwise Classified; Administrative Services Professional Pharmacy Services Care Coordination And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately) Per Diem	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_

S9381	Delivery Or Service To High Risk Areas Requiring Escort Or Extra Protection Per Visit	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S9401	Anticoagulation Clinic Inclusive Of All Services Except Laboratory Tests Per Session	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S9430	Pharmacy Compounding And Dispensing Services	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S9432	Medical Foods For Non-Inborn Errors Of Metabolism	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S9434	Modified Solid Food Supplements For Inborn Errors Of Metabolism	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S9435	Medical Foods For Inborn Errors Of Metabolism	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S9436	Childbirth Preparation/Lamaze Classes Non-Physician Provider Per Session	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S9437	Childbirth Refresher Classes Non-Physician Provider Per Session	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S9438	Cesarean Birth Classes Non-Physician Provider Per Session	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S9439	Vbac (Vaginal Birth After Cesarean) Classes Non-Physician Provider Per Session	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S9441	Asthma Education Non-Physician Provider Per Session	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S9442	Birthing Classes Non-Physician Provider Per Session	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S9444	Parenting Classes Non-Physician Provider Per Session	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S9445	Patient Education Not Otherwise Classified Non-Physician Provider Individual Per Session	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review. Unlisted or Undefined	_	_	_
S9446	Patient Education Not Otherwise Classified Non-Physician Provider Group Per Session	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review. Unlisted or Undefined	_	_	_
S9447	Infant Safety (Including Cpr) Classes Non-Physician Provider Per Session	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S9449	Weight Management Classes Non-Physician Provider Per Session	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S9451	Exercise Classes Non-Physician Provider Per Session	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_

S9454	Stress Management Classes Non-Physician Provider Per Session	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S9472	Cardiac Rehabilitation Program Non-Physician Provider Per Diem	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S9473	Pulmonary Rehabilitation Program Non-Physician Provider Per Diem	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S9482	Family Stabilization Services Per 15 Minutes	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S9537	Home Therapy; Hematopoietic Hormone Injection Therapy (E. G. Erythropoietin G-Csf Gm-Csf); Administrative Services Professional Pharmacy Services Care Coordination And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately) Per Diem	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S9542	Home Injectable Therapy Not Otherwise Classified Including Administrative Services Professional Pharmacy Services Care Coordination And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately) Per Diem	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
S9558	Home Injectable Therapy; Growth Hormone Including Administrative Services Professional Pharmacy Services Care Coordination And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately) Per Diem	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S9560	Home Injectable Therapy; Hormonal Therapy (E. G. ; Leuprolide Goserelin) Including Administrative Services Professional Pharmacy Services Care Coordination And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately) Per Diem	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S9562	Home Injectable Therapy Palivizumab Or Other Monoclonal Antibody For Rsv Including Administrative Services Professional Pharmacy Services Care Coordination And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately) Per Diem	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S9810	Home Therapy; Professional Pharmacy Services For Provision Of Infusion Specialty Drug Administration And/Or Disease State Management Not Otherwise Classified Per Hour (Do Not Use This Code With Any Per Diem Code)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_

S9900	Services By A Journal-Listed Christian Science Practitioner For The Purpose Of Healing Per Diem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S9960	Ambulance Service Conventional Air Services Nonemergency Transport One Way (Fixed Wing)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S9961	Ambulance Service Conventional Air Service Nonemergency Transport One Way (Rotary Wing)	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
S9970	Health Club Membership Annual	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S9976	Lodging Per Diem Not Otherwise Classified	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review. Unlisted or Undefined	_	_	_
S9977	Meals Per Diem Not Otherwise Specified	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review. Unlisted or Undefined	_	_	_
S9981	Medical Records Copying Fee Administrative	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S9982	Medical Records Copying Fee Per Page	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S9986	Not Medically Necessary Service (Patient Is Aware That Service Not Medically Necessary)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S9988	Services Provided As Part Of A Phase I Clinical Trial	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S9989	Services Provided Outside Of The United States Of America (List In Addition To Code(S) For Services(S))	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S9990	Services Provided As Part Of A Phase Ii Clinical Trial	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S9991	Services Provided As Part Of A Phase Iii Clinical Trial	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S9992	Transportation Costs To And From Trial Location And Local Transportation Costs (E. G. Fares For Taxicab Or Bus) For Clinical Trial Participant And One Caregiver/Companion	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S9994	Lodging Costs (E. G. Hotel Charges) For Clinical Trial Participant And One Caregiver/Companion	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
S9996	Meals For Clinical Trial Participant And One Caregiver/Companion	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 Services Up To 15 Minutes	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_

T1006	Alcohol And/Or Substance Abuse Services Family/Couple Counseling	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
T1009	Child Sitting Services For Children Of The Individual Receiving Alcohol And/Or Substance Abuse Services	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
T1010	Meals For Individuals Receiving Alcohol And/Or Substance Abuse Services (When Meals Not Included In The Program)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
T1012	Alcohol And/Or Substance Abuse Services Skills Development	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
T1013	Sign Language Or Oral Interpretive Services Per 15 Minutes	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
T1014	Telehealth Transmission Per Minute Professional Services Bill Separately	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
T1018	School-Based Individualized Education Program (Iep) Services Bundled	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
T1019	Personal Care Services Per 15 Minutes Not For An Inpatient Or Resident Of A Hospital Nursing Facility Icf/Mr Or Imd Part Of The Individualized Plan Of Treatment (Code May Not Be Used To Identify Services Provided By Home Health Aide Or Certified Nurse Assistant)	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
T1029	Comprehensive Environmental Lead Investigation Not Including Laboratory Analysis Per Dwelling	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
T1032	Services Performed By A Doula Birth Worker Per 15 Minutes	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
T1033	Services Performed By A Doula Birth Worker Per Diem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
T1505	Electronic Medication Compliance Management Device Includes All Components And Accessories Not Otherwise Classified	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
T1999	Miscellaneous Therapeutic Items And Supplies Retail Purchases Not Otherwise Classified; Identify Product In Remarks	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
T2001	Non-Emergency Transportation; Patient Attendant/Escort	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
T2002	Non-Emergency Transportation; Per Diem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
T2003	Non-Emergency Transportation; Encounter/Trip	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
T2004	Non-Emergency Transport; Commercial Carrier Multi-Pass	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
T2005	Non-Emergency Transportation; Stretcher Van	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
T2007	Transportation Waiting Time Air Ambulance And Non-Emergency Vehicle One-Half (1/2) Hour Increments	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_

T2012	Habilitation Educational; Waiver Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review. Unlisted or Undefined	_	_	_
T2013	Habilitation Educational Waiver; Per Hour	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review. Unlisted or Undefined	_	_	_
T2014	Habilitation Prevocational Waiver; Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review. Unlisted or Undefined	_	_	_
T2015	Habilitation Prevocational Waiver; Per Hour	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review. Unlisted or Undefined	_	_	_
T2016	Habilitation Residential Waiver; Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review. Unlisted or Undefined	_	_	_
T2017	Habilitation Residential Waiver; 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review. Unlisted or Undefined	_	_	_
T2018	Habilitation Supported Employment Waiver; Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.	_	_	_
T2019	Habilitation Supported Employment Waiver; Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.	_	_	_
T2020	Day Habilitation Waiver; Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.	_	_	_
T2021	Day Habilitation Waiver; Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.	_	_	_
T2024	Service Assessment/Plan Of Care Development Waiver	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
T2025	Waiver Services; Not Otherwise Specified (Nos)	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
T2026	Specialized Childcare Waiver; Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.	_	_	_
T2027	Specialized Childcare Waiver; Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.	_	_	_
T2028	Specialized Supply Not Otherwise Specified Waiver	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.	_	_	_
T2029	Specialized Medical Equipment Not Otherwise Specified Waiver	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.	_	_	_
T2030	Assisted Living Waiver; Per Month	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
T2031	Assisted Living; Waiver Per Diem	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_

T2032	Residential Care Not Otherwise Specified (Nos) Waiver; Per Month	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
T2033	Residential Care Not Otherwise Specified (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 Intervention Waiver; Per Diem	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.	_	_	_
T2035	Utility Services To Support Medical Equipment And Assistive Technology/Devices Waiver	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.	_	_	_
T2036	Therapeutic Camping Overnight Waiver; Each Session	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.	_	_	_
T2037	Therapeutic Camping Day Waiver; Each Session	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.	_	_	_
T2038	Community Transition Waiver; Per Service	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.	_	_	_
T2039	Vehicle Modifications Waiver; Per Service	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.	_	_	_
T2040	Financial Management Self-Directed Waiver; Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.	_	_	_
T2041	Supports Brokerage Self-Directed Waiver; Per 15 Minutes	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.	_	_	_
T2049	Non-Emergency Transportation; Stretcher Van Mileage; Per Mile	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
T2050	Financial Management Self-Directed Waiver; Per Diem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
T2051	Supports Brokerage Self-Directed Waiver; Per Diem	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
T2101	Human Breast Milk Processing Storage And Distribution Only	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
T4521	Adult Sized Disposable Incontinence Product Brief/Diaper Small Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
T4522	Adult Sized Disposable Incontinence Product Brief/Diaper Medium Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
T4523	Adult Sized Disposable Incontinence Product Brief/Diaper Large Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
T4524	Adult Sized Disposable Incontinence Product Brief/Diaper Extra Large Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
T4525	Adult Sized Disposable Incontinence Product Protective Underwear/Pull-On Small Size Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
T4526	Adult Sized Disposable Incontinence Product Protective Underwear/Pull-On Medium Size Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
T4527	Adult Sized Disposable Incontinence Product Protective Underwear/Pull-On Large Size Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
T4528	Adult Sized Disposable Incontinence Product Protective Underwear/Pull-On Extra Large Size Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_

T4529	Pediatric Sized Disposable Incontinence Product Brief/Diaper Small/Medium Size Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
T4530	Pediatric Sized Disposable Incontinence Product Brief/Diaper Large Size Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
T4531	Pediatric Sized Disposable Incontinence Product Protective Underwear/Pull-On Small/Medium Size Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
T4532	Pediatric Sized Disposable Incontinence Product Protective Underwear/Pull-On Large Size Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
T4533	Youth Sized Disposable Incontinence Product Brief/Diaper Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
T4534	Youth Sized Disposable Incontinence Product Protective Underwear/Pull-On Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
T4535	Disposable Liner/Shield/Guard/Pad/Undergarment For Incontinence Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
T4536	Incontinence Product Protective Underwear/Pull-On Reusable Any Size Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
T4537	Incontinence Product Protective Underpad Reusable Bed Size Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
T4538	Diaper Service Reusable Diaper Each Diaper	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
T4539	Incontinence Product Diaper/Brief Reusable Any Size Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
T4540	Incontinence Product Protective Underpad Reusable Chair Size Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
T4541	Incontinence Product Disposable Underpad Large Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
T4542	Incontinence Product Disposable Underpad Small Size Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
T4543	Adult Sized Disposable Incontinence Product Protective Brief/Diaper Above Extra Large Each	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
T5001	Positioning Seat For Persons With Special Orthopedic Needs	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	5/1/2024	_	Effective 5/1/2024
T5999	Supply Not Otherwise Specified	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	5/1/2024	_	Effective 5/1/2024
V2199	Not Otherwise Classified Single Vision Lens	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	5/1/2024	_	Effective 5/1/2024

V2599	Contact Lens Other Type	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	5/1/2024	_	Effective 5/1/2024
V2627	Scleral Cover Shell	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	5/1/2024	_	Effective 5/1/2024
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	Addition To Lens; Tint Any Color Solid Gradient Or Equal Excludes Photochromatic Any Lens Material Per Lens	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 Any Type Solid Gradient Or Equal Any Lens Material Per Lens	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
V2762	Polarization Any Lens Material Per Lens	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	5/1/2024	_	Effective 5/1/2024
V2782	Lens Index 1. 54 To 1. 65 Plastic Or 1. 60 To 1. 79 Glass Excludes Polycarbonate Per Lens	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
V2783	Lens Index Greater Than Or Equal To 1. 66 Plastic Or Greater Than Or Equal To 1. 80 Glass Excludes Polycarbonate Per Lens	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
V2787	Astigmatism Correcting Function Of Intraocular Lens	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
V2788	Presbyopia Correcting Function Of Intraocular Lens	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_

V2790	Amniotic Membrane For Surgical Reconstruction Per Procedure	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
V2797	Vision Supply Accessory And/Or Service Component Of Another Hcpcs Vision Code	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
V2799	Vision Item Or Service Miscellaneous	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
V5090	Dispensing Fee Unspecified Hearing Aid	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
V5095	Semi-Implantable Middle Ear Hearing Prosthesis	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	_	_
V5267	Hearing Aid Or Assistive Listening Device/Supplies/Accessories Not Otherwise Specified	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_

V5269	Assistive Listening Device Alerting Any Type	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
V5270	Assistive Listening Device Television Amplifier Any Type	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
V5271	Assistive Listening Device Television Caption Decoder	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
V5272	Assistive Listening Device Tdd	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
V5273	Assistive Listening Device For Use With Cochlear Implant	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	_	_	_
V5274	Assistive Listening Device Not Otherwise Specified	Non Covered: Procedure/service not covered by the Plan. Not subject to utilization review.	_	_	_
V5287	Assistive Listening Device Personal Fm/Dm Receiver Not Otherwise Specified	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	8/1/2024	_	Effective 8/1/2024
V5298	Hearing Aid Not Otherwise Classified	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_
V5299	Hearing Service Miscellaneous	Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review.	_	_	_

0823T	Transcatheter Insertion Of Permanent Single-Chamber Leadless Pacemaker Right Atrial Including Imaging Guidance (Eg Fluoroscopy Venous Ultrasound Right Atrial Angiography And/Or Right Ventriculography Femoral Venography Cavography) And Device Evaluation (Eg Interrogation Or Programming) When Performed	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	5/15/2024	_	Effective 5/15/2024
0824T	Transcatheter Removal Of Permanent Single-Chamber Leadless Pacemaker Right Atrial Including Imaging Guidance (Eg Fluoroscopy Venous Ultrasound Right Atrial Angiography And/Or Right Ventriculography Femoral Venography Cavography) When Performed	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	5/15/2024	_	Effective 5/15/2024
0825T	Transcatheter Removal And Replacement Of Permanent Single-Chamber Leadless Pacemaker Right Atrial Including Imaging Guidance (Eg Fluoroscopy Venous Ultrasound Right Atrial Angiography And/Or Right Ventriculography Femoral Venography Cavography) And Device Evaluation (Eg Interrogation Or Programming) When Performed	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	5/15/2024	_	Effective 5/15/2024
0826T	Programming Device Evaluation (In Person) With Iterative Adjustment Of The Implantable Device To Test The Function Of The Device And Select Optimal Permanent Programmed Values With Analysis Review And Report By A Physician Or Other Qualified Health Care Professional Leadless Pacemaker System In Single-Cardiac Chamber	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria.	5/15/2024	_	Effective 5/15/2024
Q4303	Complete Aa Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).	7/1/2024	_	Add effective 07/01/2024

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Please note that checking eligibility and benefits and/or the fact that a service has been prior authorized is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered. If you have questions, contact the number on the member's ID card.

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. Always check eligibility and benefits first through the Availity® Essentials (availity.com) or your preferred web vendor portal to confirm coverage and other important details, including prior authorization or pre-notification requirements and vendors, if applicable. For some services/members, prior authorization may be required through Blue Cross and Blue Shield of Oklahoma (BCBSOK). For other services/members, BCBSOK has contracted with Carelon Medical Benefits Management for utilization management and related services.

Services performed without prior authorization, if required, will be denied for payment and providers may not seek reimbursement from BCBSOK members. Obtaining prior authorization is not a substitute for checking eligibility and benefits.

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